			1 _ State	Department of Health and Me Certificate of Death		Z1105 23001
			Registrar Decedent's Name (First, Middle, Last)		Reg. No. 2. Date of Death Month Death	3. Time of Death
	Physici /Media		James Veloatch		July 8	3 2005 6:41 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Catonsville	4	baltinore
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last b	birthday) If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Year	9 Birthplace (State or Foreign
	Director		Usual Residence of Decedent	Yrs.	12-17	North Carolina
	ryland how			own or Location		10d. Inside City Limits
	he Ma	ecto	Maryland Howard	Columbia	10.0	1 □ Yes 2 No
	death with the Maryland ms 23s or 28e-f show must be rediffed at	Funeral Director	9081 Goldamber Garth	10f. Zip Code 21045	10g. C	Citizen of What Country?
	ems 2	ınera	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ric	ify Yes or No-	U.S.A 14. Race - American Indian, Black, White, etc.
36	72 hours after death with the Marylan natural; or items 23c or 28e-f show alsa Exacilher mult be rediffed at	by Fu	1 Never Married 2 Married 1 Yes, Give 3 Widowed 4 Divorced 1 Yes, or Dates:	1 ☐ Yes 2 No Specify:	, , , , ,	Specify:
5-0036	"natural",	ted	15. Decedent's Education 16	5a. Decedent's Usual Occupation (Give kind of work done during most of working	16b.	Black Kind of Business/Industry
2121	C - 8	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	00	1 . 1 . 1 . 21
d 2	filed v Hygie other t	a)	17. Father's Name (First, Middle, Last)	Driver 18. Mother's Name (i	First, Middle, Maide	nool District
/lan	2 should be filed within and Mental Hygiene. Is marked other then sumetic event, I' & M.	To B	Edward DeLoatch		Juleair	ne Davis
Maryland	s 1 and 2 should be filed withing Hogiene. If Health and Mental Hygiene. Item 27 le marked other then other treumetic event, If a M			9b. Mailing Address (Street and Number or Rural F	Route Number, City	or Town, State, Zip Code)
	s 1 and 2 of Health item 27 other tr		Ms. B. Bonita Nunez Daughter 20a. Method of Disposition 20b. Place	7682 Old Rockbridge Drive Floor Disposition (Name of Date Drive Page 1997)	lkridge, Maryl te 20c.	and 21075 Location - City or Town, State
imo	Page: nent of ant: If i		1 ■ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	ot Louis Monaries Coulty 07/15	5/2005	Marriottsville, Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ot once.		21, Signipriure/bit Funerai Service lice see	22. Name and Address of actity		Transition, maryima
	11-		23a. Part1. Enter the disease on complications that caused the death. D shock, or heart failure. Ust only one cause on each line.	Slack Funeral Home, F 3871 Old Columbia Pil o not enter the mode of dying, such as cardiac or	ke Ellicom City	y, MD 21043 Approximate
13	Physician .		shock, or neart failure. Ust only one cause on each line. Immediate Cause (Final disease or conditiona	- 1 [.		Interval Between Onset and Death
7	/Medical Examiner		resulting in death) Due to (or as a consequence)			Officions
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	ce of):		i man th
	cuted nd ransit	Examiner	that initiated events			unthan
8760,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence	æ of):		
687	ificate g physi as the l	edical	d			
Box	death certific e attending pl d for use as t	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea			23d. Date of delivery
.O.	the dea y the at sched fo	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown			Month Day Year
Δ.	w requires that the de been signed by the s should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ords	requires that een signed b hould be deta	ted b			1 Tes	2 No 3 Probably 4 Denknown
Sec.	as as	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Records,	olcien: The certificate harector, page		25. Was case referred to medical	26. Place of Death (1□ Yes 2□	
f Vi	Phyeicien: this certification	To Be	examiner?	Othor		6 ☐Other (Specify)
ou of	ding Physicien: n. After this certific funeral director,	on:	1 ☑ Natural 5 ☐ Pending (Month, Day Year)	Injury Work?	3d. Describe how in	jury occurred
Division	Attend death ctor: /	flcat	2 Accident investigation 3 Sucide 6 Could not be determined 28e. Place of Injury - At home.	M 1 ☐ Yes 2 ☐ No , farm, street, factory, office 28		and Number or Rural Route Number,
Ρ	s after s after el Dire ed in b	Certification:	3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could flot be determined 28e. Place of Injury - At home, building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, Sta	ate)
	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funera	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowled and manner stated.	ige, death occurred at the time, date and place, an and/or investigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. E	Date signed (Month, Day, Year)
			Cimm. xlostomp	055915		1-9-05
	6		30. Name and address of person who completed cause of death (Item 23a	wher Health Coton	Sville,	MD
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	harts!		
DH	Registi MH 17 Rev 1/2	-	JUL 1 4 2005 Box St.	Age of the second		

ORIGINAL

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and	Wientaniny		
1 - State Registrar Certificate of Death		Reg. No 20	05_23002
1. Decedent's Name (First, Middle, Last)	2. Date of De Month JULY	nath	3. Time of Death 3:00 A. M
Physician /Medical Joseph Perry Fulton 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea		4c. County	
VA MARYLAND HEALTH CARE SYSTEM PERRY PO	TVIC		CECIL
Funeral Director 216-20-2930 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 74 Yrs. 7 Months Days Hours Min	n. 8. Date of Bir (Month, Da Aug 28	1930	9. Birthplace (State or Foreign Country) Georgia
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Baltimore N/A Baltimore			1X1Yes 2 □ No
Maryland N/A Baltimore Maryland N/A Baltimore 10f. Zip Code 1190 West Northern Parkway 21210 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1951 1. Never Married 1. Nev		10g. Citizen of V USA	Vhat Country?
1190 West Northern Parkway 21210 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? 14. Was Decedent Office of Hispanic Origin? 15. Was Decedent Office of Hispanic Origin? 16. Was Decedent Office of Hispanic Origin?	(Specify Yes or No		e - American Indian,
्र चे के 3 X Widowed 4 □ Divorced Year or Dates: 1952	eno rican, etc.)		ek, White, etc.
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of w	vorking	16b. Kind of Bu	usiness/Industry
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		Acco	unting
Do Se to the second of the sec	lame (First, Middle	e, Maiden Suman	ne)
John Fulton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Informant)		ner. City or Town.	State, Zip Code)
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I 19b. Mailing Addre			
Bever 11 Moritite, Daughter 180 South West 12th. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location -	City or Town, State
1 Burial 2 X Cremation 3 Removal from State 1 Donation 5 Other (Specify) Metro Crematory Inc. 07	/13/05		re, Maryland
21. Signature of Funeral Service dispuses 22. Name and Address of Facility Cremation Society Thomas Gregor 29. Prederick Ros	y Of Mary ad Balti	yland, I more, Ma	nc. ryland 21228
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence of):			UNKNOWN
Sequentially list conditions.			
ff ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.			
C a c.m. W			
edicate to physical property of the physical p			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			ate ol delivery onth Day Year
1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use con	tribute to the cause of death?
parint in signe at it	1	Yes 2□No	3 Probably XX Unknow
Completed Completed	24a. Wa	is an 24b. opsy formed?	Were autopsy findings available prior to completion of cause of death?
COULT : . page	1 ☐ Yes	XXNo	1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2X No 1 Yes 2X No 2 ER/Outpatient 3 DOA Other: 4 Nursin	Death (Check only ng Home 5 ☐ Re		her (Specify)
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? (Month, Day Year) 28c. Injury at Work?	28d. Describe	e how injury occu	rred
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28a. Date of Injury At home, larm, street, factory, office 28a. Place of Injury - At home, larm, street, factory, office 28a. Place of Injury - At home, larm, street, factory, office 28a. Date of Injury 28a.	281. Location	(Street and Num	ber or Rural Route Number,
determined determined building, etc. (Specify)	City or T	own, State)	
25. Was case referred to medical examiner? 1 Yes	lace, and due to the	ne cause(s) and m e, date and place	nanner as stated. , and due to the cause(s)
29c. License number			ed (Month, Day, Year)
hands frankl is D42800		JULY 1	3, 2005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS BIONDO, M.D., VA MARYLAND HEALTH CARE SYSTE	M, PERRY	POINT,	MD 21902
State Registrar 31. Date filed (Month, Day, Year) 32. Segistrar's Signature JUL 1 4 2005			

DHMH 17 Rev 1/2001

Funeral

Director

the Maryland

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. g. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 07/13/2005 **Physician** 1:40A Lloyd Albert Fries /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Genesis HealthCare Severna Park Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 01/13/1941 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Min. 10 M 2 T F Yrs. 217-38-3719 64 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 ☐ Yes 2 No rector Anne Arundel Pasadena MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ā U.S.A. 21122 253 Wendover Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Specify: White 16b. Kind of Business/Industry General Motors 18. Mother's Name (First, Middle, Maiden Surname) Ruth Poling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 253 Wendover Road, Pasadena, MD 21122 20c. Location - City or Town, State Bayview Crematory 07/13/05 Baltimore, MD 22. Name and Address of Facility G. J. Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 300 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of centifier 032036 MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Our Nove 2/UP 1, 1000 Min Chirler, MD 2/6/9 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

ID

Registrar

wen & Speck ORIGINAL

				For 1 State	• •	ryland / Dep	artment of	Health and M	ental Hyg	iene	
				Registrar		Ce	ertificate of	f Death		eg. Ng. () () 5	
_		Physici		1. Decedent's Name (First, Middle, Las Elizabeth S. Gr					2. Date of Death Month	Day Ye	
		/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Death		4c. County of [
	1			St Agnes Ho	ospital			imore		Mari	
	Т	Funeral		5. Social Security Number 6. S	ex 7. Age □M 2 🕮 F	(In yrs. last birthday	/) If Under 1 Yea Months Day	r If Under 24 Hrs. s Hours Min.	8. Date of Birth Sep . To	Year 018 9.	Birthplace (State or Foreign Pennsylvania
		Director		163-14-0200 1 Usual Residence of Decedent		86 Yrs.			3ep. 10	,, 1710	
		and		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
		Ba-f sho	ctor	MD Balti	more		Arbut			0-00	1 Tyes X No
		filed within 72 hours after death with the Maryland Hygiene. other than "netural", or Items 23a or 28a-f show ent, It a Medical Examinat must be notified at	Funeral Director	10e. Street and Number 1030 E1m Road			10f. Žîp Code	21227	'	Og. Citizen of Wha United	
		death	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent o	f Hispanic Origin? (Spe uban, Mexican, Puerto	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
E	ဖွ	or ite	Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🕅 N	0	1 ☐ Yes 2 ☒ N		, , , , , , ,	Specify:	White
Grayson	215-0036	ural',	d by	3 AWidowed 4 □ Divorced	Year or Dates:						
9	5-	"netu	ete	15. Decedent's Ed (Specify only highest gra	lucation ide completed)	16a. Dec	edent's Usual Occ on kind of work dor OO NOT use reti	cupation ne during most of works ired)	ng	16b. Kind of Busin	ess/industry
	212	d within 72 ho piene. r than "netu ine Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		pervisor		Insura	nce
S.		0	Be	17. Father's Name (First, Middle, Last) James Shrom				18. Mother's Name Myrtle F		Maiden Sumame)	
Y	7	should Me mark matic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Stre	et and Number or Rura	l Route Number	, City or Town, Sta	te, Zip Code)
pr 1	∑	and 2 sealth ar n 27 is ner treu		Linn Grayson Son		1479	Mallard	l Landin B	lvd. Ja	cksonvill	e, FL 32259
Elizabeth	Ē,	s 1 at f Hea if Hea othe		20a. Method of Disposition		20b. Place of Dis	position /Name of			20c. Location - Cit	
U	Ë	Page nent c nt: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Meadowi	rage Memo Park	7-13-	2005	Elkridge	MD
	Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other treumatic evonce.		21. Consture of Funeral Lice	Maurile	11/10	1328 Sul	dress of Facility Amo	Rd., A:	rbtuus, N	ome, Inc. 1D 21227
				23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not e	enter the mode of o	tying, such as cardiac c	r respiratory arre	est,	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	0110 02000 011 02011 1111	Findocardi.	tre				Onset and Death
	7	/Medical		resulting in death)	Due to (or as a	a consequence of):	11.5				
		Examiner	Н	Sequentially list conditions	b	Atrial fi	brillation				
	_	p #	ner	Sequentially list conditions, if any facing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of):					
		ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as:	Bacterem a consequence of):	ia				
	60,	eath certificate be executed attending physician end for use as the burial-transit	cai E		•	a consequence or,					
	87	physi	dic		_ d					-	
	Box 68760,	certifi Iding	Physician/Medi	IF FEMALE:	23c. If yes, outcome of					23d. Date of	f delivery
	Bo	atten atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth : 4 ☐ Pregnant at		3 □Ectopic pregna 5 □ Other (s <i>pecify)</i>			Month	Day Year
	P.O.	the d by the ached	hysi	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9□ Unknown						
	ds, P	The law requires that the death certificate be executed to has been signed by the attending physician end bage 2 should be detached for use as the burial-transi	þ	Part II. Other significant conditions	ontributing to death bu	ut not resulting in the	underlying cause	given in Part I.	23e. Did toi		te to the cause of death? Probably 4 Unknown
	cor	w requir been si should l	lete						24a. Was a	an 24b. We	re autopsy findings available
	Re	vicien: The lav certificate has rector, page 2	Completed						autops perform	med? dea	r to completion of cause of th? Yes 2 No
	ta	en: tifica tor, p	a	25. Was case referred to medical				26. Place of Death			
	\	ystol	To B	examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ER/Outpat	ient 3 DOA	Other: 4 Nursing Ho	me 5 ☐ Reside	ence 6 Other	(Specify)
	0 U	ng Pł fter tł neral		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28b. Time y Year) Injur	y \	Nork?	28d. Describe ho	ow injury occurred	
	Sio	eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No	OR Location (C	Yroot and Alumbar	or Rural Route Number,
	Division of Vital Records,	s after d al Direct ad in by	Certification:	4 Homicide determined		ury - At home, farm, c. <i>(Specify)</i>	street, factory, offi	ce	City or Town		or nural noble wornself,
		To the Hospitel or Attending Physicien: The i within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or	eath occurred at the investigation, in m	e time, date and place, ny opinion, death occurr	and due to the c red at the time, d	ause(s) and mann date and place, and	er as stated. I due to the cause(s)
		To the To the comp	X	29b. Signature and title of cortifier	0		_	ense number	2	29d. Date signed (I	
		.00		▶ 89inh, ~	>1		У	54996		July 9	,2005
		18		30. Name and address of person who	completed cause of d	eath (Item 23a) (Typ	oe, Print)	Polto MD	21220		
		1		Bichwag M 31. Date filed (Month, Day, Year)	1 · 4/inh 90	of S. Cate	on Ave.	Balto., MD	Z1ZZ9		
		St: Regist	ate rar	U. Sale filed (Morter, Day, Teal)	_ 1 4 Enda	THE THE PARTY OF	77				

		For State Registrar			Ce	rtificate c	of Deat	h		Reg. N	2005	22225
O. Dhuninia		1. Decedent's Name (First, Middle,	Last)						2. Date of D Month	D	ay Year	(3. Tip of part)
Physicia /Medic		Constance May							JULY	10		8:30 AM
Examin	er	4a. Facility Name (If not institution,		r)		4b. City, Tow	n, or Locatio	n of Death		4	lc. County of Death	
		6498 Summer Cl		an /In vrs	last birthday)	Colum		er 24 Hrs.	9 Date of B	lirth	Howard	place (State or Foreign
neral ector		5. Social Security Number 9 1 19 26 9 14 9	1□M 2XF	78		Months Da		Min.	8. Date of B (Month, D FEB • 2	8, Yea		place (State or Foreig ntry) inois
928		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	neation					1	IOd. Inside City Limits
NO N	ō	MD Howar	đ		lumbia	Joacion						1 □ Yes 🔏 No
other traumatic event, I'm Medical Examinational benedified at	Director	10e. Street and Number				10f. Zip Coo	е			10g. C	Citizen of What Cou	ntry?
at pe	ai D	6498 Summer Cl	oud Way			210	45				USA	
	Funeral	11. Marital Status	12. Was Deceder Armed Forces		I.S. 13.	Was Decedent If Yes, specify (of Hispanic (uban, Mexic	Origin? (Spe	cify Yes or N Rican, etc.)	10-	14. Race - Americ Black, White,	
	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ∑ If Yes, Give Year or Dates	•	1	1□Yes 2∏X					Specify: Whi	.te
		15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Oc	cupation	ost of worki	na	16b.	Kind of Business/In	dustry
	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	kind of work do DO NOT use re	tired)	00. 01 1101111	<i>'</i> 9			
		12 17. Father's Name (First, Middle, La	4		Trans	criptio		ther's Name	(First, Middle	lo Maide	Medical	
	Be	Henry Vernon						Edna G		o, maroc	an Sumamo,	
	ဥ	19a. Informant's Name/Relationship			19b. Maili	ng Address (Str				ber, City	or Town, State, Zip	Code)
		Amy Stefhon - d				Summer						_
1		20a. Method of Disposition			Place of Dispo	osition (Name o			ate		Location - City or To	own, State
once.		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	cify)		adowrio	dge Mem	Park		3/2005		lkridge,	
OUC.		21. Signature of Funeral Service Li	censee 7		G2 72	ery L. I 1250 Wash	dress of Fac Kaufma ningto	n Fune n Blvo	eral Ho	ome (krid	Meadowri	dge MP, Inc 1075
		23a. Part1. Enter the disease or shock, or heart failure. List of	omplications that cause liv one cause on each	ed the deat							1 1 1 1	Approximate Interval Between
n		Immediate Cause (Final disease or condition	17	est		ca						Onset and Death
al		resulting in death)	Due to (or a	is a consec								
ier		Sequentially list conditions,	b. Due to (or a	e a consec	mance off-							·
Dullai-trailsit	nine	if any, leading to immediate cause. Enter Underlying Causa cuiscasa or injury that initiated events	Dua to (01 a	13 a CO1136C	querice ory.							
	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consec	quence of):							
	dicati		d									
	Medi	IF FEMALE:								1		
	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	aldeath 3	Ectopic pregna					23d. Date of delive Month	ory Day Year
3	Physician/Me	1 Yes 2 No	4□Pregnant 9□ Unknown	at time of c	death 5	Other (specify)					
	Ph	Part II. Other significant condition	s contributing to death	but not res	sulting in the u	nderlying cause	given in Pai	rt I.	23e. Did	tobacco	use contribute to the	ne cause of death?
len en ni	d by								10	Yes :	2□No 3□Prob	ably 4 Unknown
200	Completed								24a. Wa			psy findings available
	mo								peri	opsy formed? 2 \square	death?	mpletion of cause of 2□ No
- 1	a)	25. Was case referred to medical					26. Pla	ice of Death	(Check only			
- 1	To B	examiner? 1 🗌 Yes 2 🗽 No	Hospital: 1 🗌 Inpa	tient 2	ER/Outpatier	nt 3 DOA	Other: 4 🗆	Nursing Hor	ne 🚧 Res	sidence	6 □Other (Specify	y)
		27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time o Injury	f 28c. I	njury at Work?	2	28d. Pescribe			
	cati	2 Accident investiga 3 Suicide 6 Could no	t he				☐ Yes 2					
	Certification:	4 Homicide determin	288. Flace of I	njury - At h etc. <i>(Specii</i>	ome, tarm, sti fy)	reet, factory, off	ce		City or To		and Number or Rura te)	() Moute Number,
	edicai (29a. Certifier (Check only one) Certifying 2 Medicel Expression)	Physicien: To the best teminer: On the basis and manner:	of examina	owledge, deat ation and/or in	h occurred at th vestigation, in n	time, date ny opinion, d	and place, a eath occurre	and due to the	e cause(, date ar	s) and manner as sind place, and due to	tated. the cause(s)
(2002)	Me	29b. Signature and title of certifier	and marrier	71210			ense numbe				ate signed (Month,	
		Xylian	and				830				-y 11 2c	
)		30. N me and address of person w	no completed cause of	death (Iter	m 23a) (Type,	Print)	crac	s st	- TOW	200	Mozn	Loy
	7	31. Date filed (Month, Day, Year)	32. Regis	rar's Signa	ature							
Sta egistra	-		4 2005	,								

Physicia /Medic Examin	a la la		st)						2. Date of De	Bath Day	Year 3.1	ime or Death
Examin		James		F.				ggs II	IJULY	9, 20	05 9:3	32P.
	er	4a. Facility Name (If not institution, give		1				ocation of Dea	th	4c. County		
5 × ×		NORTHWEST HOSPITA 5. Social Security Number 6. S		je (In yrs. la:	st birthday)	If Under	DALLS 1 Year	I Under 24 Hr	s. 8. Date of Bi	dh	IMORE 9. Birthplace (State or Foreig
Funeral Director			Д М 2□ F	44	Yrs.	Months	Days	Hours Min	. (Month, Da	ау, ^{Уеаг)} О 61	9. Birthplace (Country) MI	
Maryland fed at		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. In:	side City Limit
	tor	MD Baltime	ore	Ra	ndal	lsto	wn				1 (Yes XXN
with the a or 28s	Director	10e. Street and Number				10f. Zip	Code			10g. Citizen of W	/hat Country?	
a 23a	ral	9909 Southall						133			S.A.	
Items	Funeral	11. Marital Status 1 Never Married Married	12. Was Decedent Armed Forces?	•	13.	Was Deced If Yes, spec	dent of Hisp orfy Cuban,	panic Origin? (Mexican, Pue	Specify Yes or No rto Rican, etc.)	o- 14. Race Blac	e - American Ind k, White, etc.	ian,
7 Z = 1	þ	3 Widowed 4 Divorced	1 ☐ Yes 🔀 🕅 If Yes, Give X Year or Dates:	140		1 ☐ Yes 2	% No	Specify:		Specify	Blac	ck
"natural"	etec	15. Decedent's Ed (Specify only highest gra	fucation de completed)		(Give	dent's Usua kind of wor	rk done du	on ring most of wo	orking	16b. Kind of Bu	siness/Industry	
she.	Completed	Elementary/Secondary (0-12) 6th grade	College (1-4or	5+)		DO NOTUS Disa				Dis	sabled	
other	ပိ	17. Father's Name (First, Middle, Last)				<i>5</i> -54	·		me (First, Middle	, Maiden Sumam		
z should be and Mental I is marked or raumatic eve	To Be	James Griggs J	r.				M	arie l	Matthew	s		
and h		19a. Informant's Name/Relationship (Type, Print) Mot							er, City or Town,		
of Health Item 27		Marie Consuell	a Johnso	_				1 Road		allstov		
or off		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		cen	netery, crer	natory or of	ther place)	1	Date	20c. Location -		
it re ither itent njury		4 □ Donation 5 □ Other (Specification of Fineral Service Licer		King					14/05	Randall	Lstown	, Ma
permit. Pages Department of Important: If I any Injury or o		21. Signature of Partieral Service Licer	Shr		Ma	Name and	F/H	West	P-1+;	more, N	44 211	215
ec		22a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	d the death.							Appro	eximate al Between
	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as c Due to (or as									
by the attending ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant al 9 □ Unknown	2 Fetal d	eath 3	Ectopic pre				23d. Date Mon	of delivery oth Day	Year
igne bed	Ď	Part II. Other significant conditions o	ontributing to death b	ut not result	ing in the ui	nderlying ca	ause given	in Part I.	23e. Did t	obacco use contri Yes 2 No		e of death?
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page 2	Completed								auto perio	ormed?	rior to completio eath? XYes 2 ☐ N	n of cause o
certificete	Bec	25. Was case referred to medical examiner?					2	6. Place of De	ath (Check only o			
this ldi	၉	1 X Yes 2 □ No	Hospital: 1 ☐ Inpatie		VOutpatien			4 🗀 Nul Silig		dence 6 □Othe		
After	lon	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da		8b. Time of Injury	28	8c. Injury a Work?			how injury occurre	əd	
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effer Direct of in by	erti	4 Homicide determined	home	c. (Specify)		,	,			Street and Number wn, State) 9909 Stown, Ma		11 R
hours unera ly fille	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2X Medical Exam	ysician: To the best niner: On the basis o and manner st	f examinatio	edge, death n and/or inv	occurred a	al the time, in my opin	date and plac	e, and due to the	cause(s) and mar	ner as stated	use(s)
9 E B B B B B B B B B B B B B B B B B B	Me	29b. Signature and title of certifien	and marrier st	, ,		29c.	License r			29d. Date signed	(Month, Day, Y	ear)
within 24	~			7 . /			OCME	i,				
within 24 hours after death. To the Funeral Director: After completely filled in by the funer	~	• ()	W. 1	7	_			•		JULY 10), 2005	
Within 24	~	30. Name and address of persony ho	completed cause of c	leath (Item 2	(3a) (Type,	Print) 11			- D-1.	JULY 10		01.001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Tim of pear 1. Decedent's Name (First, Middle, Last) Month July **Physician** ĺΊ, 19:29 Pansy Green /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore University Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-18-1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours 1 □ M 2 XF Days 76 220-22-2986 Virginia Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a, State 10h County r than "netural", or Itema 23a or 28a-f ehow the Medical Examinar must be mailfied at 1X Yes 2 □No Baltimore MD NA Direct 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 1344 Mosher Street 21217 TISA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: þ Black 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fift
Department of Health and Mental Hy
Importent: if Item 27 is marked oth
eny injury or other traumatic event
900.8. Be Margaret Handy Floyd Kellum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21217 Fern Dorsey/ Daughter 1614 McKean Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veteran 07-20-05 22. Name and Address of Facility 21. Signati re of Funeral Service Licencee Wylie Funeral Home 638 N. Gilmor St. Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) the **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician by Physician/Medical the use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year be detached for 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ል 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 nknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 A Yes 1 Yes 2□ No certificate 2 No Physician: Be completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 XYes 2 ☐ No 1 Inpatient ٩ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No s after death. M investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME July 12, 2005 30. Name and address of person who completed cause of path (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 THEODORE MIKE

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:42 a M **Physician** July 12,2005 Harrington Clay C. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk Rd. 88 Avalon 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**X** M 2□ F July 6,1911 94 Virginia 234-32-7093 Director Usual Residence of Decedent a filed within 72 hours after death with the Maryland at Hygiene.
other than "neturel", or Iteme 23a or 288-f show 10c. City Town or Location 10d. Inside City Limits 10a. State 10b County r than "neturel", or Iteme 23a or 28a-f show the Medical Exerciper must be notified at 1 ☐ Yes 2 No Baltimore Dundalk **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21222 3461 Loganview Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Mining Coal Miner 5 years 18. Mother's Name (First, Middle, Maiden Surname)
Josephine Osborne 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should ba file Department of Health and Mental Hy Important: If Item 27 Ie marked oth any injury or other treumatic event Claybe Harrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1060 Old Manchester Road, Westminster, MD. 21157 son Robert Harrington 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 15, WBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, MD 21. Signatuje of Funeral Service Licensee 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician - 145 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day signed by the atte 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 1□ Yes 2☑ No Division of Vital il or Attending Physician: after death. 26 Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Nother (Special) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 Z No 28a. Date of Injury (Month, Day Year) filled in by the funeral 28d. Describe how injury occurred 28b. Time of Injury at Work? 27. Manner of Death Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year 29c. License number 29b. Signature and title of certifier wither D0034 Harrely 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2112 Authoux Dunda/4 32. Regitrar's Signature Harre 31. Date filed (Month, Day, Year) State 1 4 2005 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. N. 1 1 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vasi HAGGINS **Physician** 10:40 PM ALFONCE 2005 JULY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NA HOSPITAL JOHNS HOPKINS BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 240-68-7554 August 66 Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 res 2 No MO Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21213 3229 1. Ftmont Avenue Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Reparen 8 18. Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) Be Lauradine Willey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue Baltimur MD 2.1215 20c. Location - City or Town, State Haggins VIVICA 3229 CliFtmont WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Park '4 □ Donation 5 □ Other (Specify) mononel 7/18/05 22. Name and Address of pacifity luse Foreral Senvoce P. B. 5126 Belain Read Bething 180 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MYELOID LEUKEMIA Immediate Cause (Final ACUTE Year disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to tor as a consequence or. Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

burial-transit

thel

attending physician

the detached

been

or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ral', or itams 23a or 28a-f show Examinar must be notified at

"natural",

other traumatic avant, I've Medical

and Mental Hygiene.

Pages 1 and 2 should be f nent of Health and Mental F int: If itam 27 ia marked of

ģ Completed

Be

Certification; To

Medical

State Registrar

filled in by the

within 24 hours a To the Funeral (

RENAL FAILURE

24a. Was an autopsy performed 2 No 24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death

5 Pending investigation

6 ☐ Could not be

determined

1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

and manner stated

MD

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

(Check only one)

29b. Signature and title of certifier

unds

2 Accident

3 🖺 Suicide

29a. Certifier

4 Thomicide

29c. License number RES-000

STREET

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

VEIDT 31. Date filed (Month, Day, Year) 600 NORTH WOLFE

JUL 1 4 2005 32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

1 Yes 2 PNo 3 Probably 4 Unknown

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Juli 2005

MARYLAND

21287

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For Stata	State of Ma	ryland / Depa			nd Me			0 = 1	20010
			Registrar	-41	Cei	rtificate of	Death	10		Reg. No.	U5 .	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last ELEANOR L.	HARDY					Month	Day	Year	1959 M
	/Media		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of		JULY	4c. Co	2005 unty of Death	1131
1	Examir	ier	UNIVERSITY OF M		DICAL CENTER		TIMORE				N/A	
	Funeral		5. Social Security Number 6. S	ex 🧪 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24		Date of Birt (Month, Da	h v Year	9. Birthpi	lace (State or Foreign
	Director	a	200-30-0205	□M 217F	66 Yrs.	Widilitis Days	riours	Si	ily as	1, 1936	Mar	yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10	Od. Inside City Limits
	Maryl f sho	tor	PA Delawa	VP.	Yeadon							1 ☐ Yes 2 ☐ No
	r 28a	irec	10e. Street and Number		1040011	10f. Zip Code				10g. Citizen	of What Coun	try?
	th wit	aiD	760 Fern St.			19050)			USA		
	tems er ca	Funeral Director	11. Marital Status	12. Was Decedent 8 Armed Forces?		Was Decedent of If Yes, specify Cul	Hispanic Origi ban, Mexican,	in? (Specif Puerto Ric	y Yes or No an, etc.)	- 14.	Race - Americ Black, White,	
36	rs afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 N If Yes, Give Year or Dates:	lo	1□ Yes 2☑ No	Specify:			Sp	ecity: Bla	cK
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "netural", or Items 23a or 28a-f show ont, the Madical Examinational be mailfied at	ted t	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occu	pation	12		16b. Kind	of Business/Inc	dustry
215	hin 7; en "n Meal	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	life.	kind of work done DO NOT use retire	n during most (ed)	of working		0: 1		24
2	filed with Hygiene Ather the	Con		4 yrs.	Socia	LI WOY	Ker				e of f	4
and	ould be fil Mental H arked oth atic even	Be	17. Father's Name (First, Middle, Last)	d.			100		,	Maiden Sui	mame)	
Maryland	should be nd Mental marked c	L	19a. Informant's Name/Relationship	Type Print)	19b. Mailir	ng Address (Stree	Elea.			ar City or To	wn. State. Zin	Code)
Ma	2 8 8		Leonard Moore	- Cous		N 601	h St	Phi	lader	Ohio	PAI	9139
re,	Health Item 27 other tr		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other pla	ace)	Date		20c. Locat	ion - City or To	wn, State
E	Part and		Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif		North Wo	ad Cemet		-18-0	05	Philad	delphia	PA
Baltimore,	permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other tr once.		21. Signature of uneral Service Licer	yeee/	- 6	2. Name and Addr	March	Funé	eral H	ome	P.A.	-0
	40 = 40		23a. Party. Enfer the disease, or com		the death. Denot and	TO FRE	shilton	FRE	5 80	Ito. Tr	10 वार्व	Approximate
			shock, of heart failure. List only Immediate Cause (Final	one cause on each lin	10.	er the mode of dy	ing, such as G	ardiac or in	өзрпакогу аг	ireat,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. WEUM	2N/A a consequence of):							
	Examiner			ISCHEM								
,	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	U	a consequence of):							
V	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):							
68760,	icate be executed physician and the burial-transit			. Due to (or as	a consequence ory.							
		edicai		d								
Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnanc	216			23d.	Date of delive	•
. B	s deat ne atte ed for	sicia	in the past 12 months? 1 \(\sum \text{Yes} 2 \) \(\mathbb{X} \) No	4☐Pregnant at		Other (specify)	-y				Month	Day Year
P.O.	that the de led by the a detached t	Phy	9 Unknown			- 4 1- 1	our in Deat I		220 Did to	obsess use	nentribute to th	e cause of death?
ds,	ires that signed I d be det	by	Part II. Other significant conditions of LUNG TRANSPLI		at not resulting in the u	nderlying cause g	ven in Part I.			res 2□N		ably 4 🖺 Unknown
Sor	w requir been s should	etec	Zorro yrexis gran						24a. Was			psy findings available
Records,	The lav	Completed							autop perfo	rmed?	prior to cor death?	npletion of cause of
Vital	ricien: Th certificate rector, pag	O	25. Was case referred to medical				26. Place of	of Death (1 □ Yes Check only o	2 No	1 🗆 Yes	2□ No
Ϋ́	Physicien: r this certifica ral director, p	To B	examiner? 1 ∐ Yes 2 X No	Hospital: 1 Inpatie	nt 2 ☐ ER/Outpatier	nt 3 DOA	ther				Other (Specify	1)
n of	ding Pł h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injui (Month, Day	y Year) 28b. Time of Injury	We		1	d. Describe l	now injury oc	curred	
Sio	ttendi Jeath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not b		AAL and for		Yes 2□N		l continu /	Ctroop and Al	umbas as Rum	I Doute Alumbas
Division	lor At after c Direc in by	Certification:	4 Homicide determined	28e. Place of Inju	ury - At home, farm, str c. (Specify)	eet, factory, office)	281	City or Tov		umber or Hura	l Route Number,
_	To the Hospital or Attending P within 24 hours after death. To the Funarel Director: After completely filled in by the funera		29a. Certifier 1X Cartifying Pt	ysician: To the best of	of my knowledge, deatl	h occurred at the	time, date and	place, and	d due to the	cause(s) and	d manner as st	ated.
	he Ho n 24 h he Fu	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/or in ited.	vestigation, in my	opinion, death	occurred	at the time,	date and pla	ce, and due to	the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	P		29c. Licer	ise number	1111			gned (Month, I	•
•			Jan Ile				16	0641		JULY	11,200	5
	10		30. Name and address of person who JAY DALAL, 30				MORE .	10 2	1201			
	Sta	tė	31. Date filed (Month, Day, Year)		ar's Signature	JU I) UNCII	101-0/10	10,2	1001			
	Regist		3111 4 4 3	ZAAS	L L	Cart .						

			1 - For State Registrar	State of Maryla		artment of rtificate o		and Me		ene . No.2 O) r-	0000
			Decedent's Name (First, Middle, Last)						2. Date of Death Month	- /	Year	Tipe Death
	Physicia /Medic		Dawn J. Howard			1			July	12, 2	005	9:15 AM
	Examin	er	4a. Facility Name (If not institution, give s 1919 Maltravers Ro	_		4b. City, Town	n, or Location o	of Death		4c. County o		undel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Ye	ar If Under 2		8. Date of Birth		9. Birth	lace (State or Foreign
į,	Director		212-80-6337	M 2₹ F 4	6 Yrs.	Months Day	ys Hours	Min.	(Month, Day, CT. 21,	1958	Coui Mar	yland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. 6	City, Town or Lo	ocation						0d. Inside City Limits
	Maryl -f sho	tor	MD Anne Aruno	del Gl	en Burn	ie						1 ☐ Yes 2X No
	th the or 28e s roll	Funeral Director	10e. Street and Number			10f. Zip Cod	e		10	g. Citizen of W	hat Cou	ntry?
	ath wii	raiD	1919 Maltravers Ro				1060				SA	
	items	nne	11. Marital Status 1X Never Married 2 Married	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2X No 	U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Orig Cuban, Mexican	gin? (Spec n, Puerto R	cify Yes or No- lican, etc.)		- Amen , White,	ean Indian, etc.
036	urs af		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 🍇 ☐ I	No Specify:			Specify:	wh.	ite
21215-0036	72 hours after death with the Maryland natural, or items 23a or 28e-f show ocal Exam ner marke confiled	Completed by	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Oc kind of work do	ne durina most	t of workin	g 1	6b. Kind of Bu		
121	within ane. than "	шрі	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use rel acility	•	or		Anne A		
9	filed v Hygie other t		17. Father's Name (First, Middle, Last)			actificy			(First, Middle, M			5015
<u>lan</u>	Ald be fental riked of tic evi	To Be	Clifton Howard				Elle	en She	ea			
Maryland	2 sho and N is ma		19a. Informant's Name/Relationship (Typ						Route Number,			
	1 and lealth am 27 ther tr		Kimberly Christon 20a. Method of Disposition			1919 Ma. osition (Name of		S RO	., Glen	Oc. Location -		21060 own. State
Baltimore,	init. Pages 1 and 2 should be filed within 72 hours after death with the Marylar andment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23a or 28e-f show injury or other traumatic event, the Medical Examinational Legisland.		1 XBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre	ge Mem.	place)	7/15.		Elkric		
慧	permit. Page Department o Important: If any injury or once		21. Signature of Funeral Service License								-	dge MP, Inc.
ä	Department of the service of the ser		MIS L. Hack	man	1/2	50 Wash	ington	Blvd	., Elkri	dge, MI) 2	1075
ı			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the de e cause on each line.	eath. Do not en	ter the mode of	dying, such as	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Met	data	the 16	elano	Der a				115.
П	Examiner			Due to (or as a cons	equence of):	name	\sim					7 455
		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):							7
V	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a cons	naunaa att							
760,	ate be executed hysician and the burial-transit	cai E		Due to (or as a cons	equence on.							
687	tificate ng phys as the											
Вох	andir use	an/M	230. was decedent pregnant	3c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fe		☐Ectopic pregna	ancy			23d. Date Mon		ory Day Year
O. E		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time o		Other (specify				MO	uı	Day
<u>α</u>	requires that the een signed by th nould be detache	/ Ph)	Part II. Other significant conditions con	tributing to death but not i	resulting in the u	ınderlying cause	given in Part I.		23e. Did tob	acco use contr	bute to t	he cause of death?
rds,	quires tha n signed I uld be det	ed by							1 🗆 Ye	2 X No	3 🗌 Prol	pably 4 Unknown
Record	S S D	Completed							24a. Was an autopsy		ere auto	psy findings available mpletion of cause of
Ä	The ate h page	Com							perform	ed? d	eath?	28 NO
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Othor		(Check only one			
of	Phys	To :	1 ☐ Yes 2 ENO	28a. Date of Injury	ER/Outpatie	III 3 DOA	4 □ Nu njury at Work?	ursing Hom 2	8d. Describe ho	nce 6 □Othe w injury occurre		y)
ion	Attending Phyrdeath. ector; After thi	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury		work? 1 ⊟ Yes 2 ⊟	No				
Division	l or Attena after deatl Director: I in by the	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st	reet, factory, offi	ice	2	8f. Location (Str. City or Town,		or or Run	al Route Number,
Ω	pital o	O	29a. Certifier Certifying Phys	ician: To the best of my l	considerate des	th occurred at th	e time date an	od place, a	nd due to the ca	use(s) and mai	nerass	tated
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edicai		ner: On the basis of exam and manner stated.	ination and/or in	vestigation, in n	ny opinion, dea	th occurre	d at the time, da	te and place, a	nd due t	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	anh.	1	29c. Lic	ense number	/-w	29	d. Date signed	(Month,	Day, Year)
}			Bund	J/1/1/			131	15.		4691	12,	1,005
	1.	(30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type	Print)	PDEN	e. (Sten	BLINA	h	1,71061
	Sta	ite	31. Date filed (Month, Day, Year)	32. Degistrar's Sig	gnatur	John Comments	W) 4V	-)	V/ (*\ /	-1/2//	1/7	N
	Registr	ar	JUL 1 4 21	ALLENS OF THE PARTY OF THE PART	7							

			For	State of M	Marylan		artment of rtificate of		nd Mental Hy			
			Registrar 1. Decedent's Name (First, Middle,	(act)		Ce	runcate of	Dealli	2. Date of D	Reg. No	05 23012	-
	Physici		Della	, Last/		На	rris		July Month	Day	Year 6:00AN	И
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town,		Death	4c. County		
			1300 E. Lanva			502		imore	4140 0 0 0 1 1 1		JA	
	Funeral Director		5. Social Security Number 213–26–1889	6. Sex 7 1 ☐ M 2 ☐ F		last birthday) Yrs.	Months Days		4 Hrs. 8. Date of B (Month, D 9-24	lay, Year)	Birthplace (State or Foreig Country) N.C.	רון
			Usual Residence of Decedent	21	74		1		3-2-	-30		
	ryland		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits ↓□Yes 2□No	
	8e-fs	Director	Md. NA			Balt	imore			10g. Citizen of		
	with ti	Dir	10e. Street and Number 1300 E. Lanva	lo Stroot	Ant	502	10f. Zip Code 212	213			JSA	
	ns 23	Funerai	11. Marital Status	12. Was Decede	nt Ever in U				in? (Specify Yes or N Puerto Rican, etc.)		e - American Indian,	_
9	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show dical Examiner must be notified at	Fun	1 Never Married 2 Marri	Armed Force ed 1 Tes 2 If Yes, Give			If Yes, specify Cu 1 ☐ Yes 2√2 No		Puerto Rican, etc.)	Specifi	ck, White, etc. v: Black	
21215-0036	rel',	d by	3 ₹ Widowed 4 □ Divorced	Year or Date	s:							
15-	"neti	iete	15. Decedent (Specify only highes	t grade completed)		(Give	dent's Usual Occi kind of work don DO NOT use retir	e durina most	of working	16b. Kind of B	usiness/Industry	
212	iene.	Completed	Elementary/Secondary (0-12) 3rd grade	College (1-4d	or 5+)		omestic	,		Other I	Peoples Homes	
שָׁל	e filec al Hyg other	Be C	17. Father's Name (First, Middle, I	Last)					's Name (First, Middle			
Maryland	s 1 and 2 should be filled within 72 hours after deal f Health and Mental Hyglene. Item 27 le marked other then "neturel", or flems other treumatic event, Ira Madical Examiner or the treumatic event, Ira Madical Examiner	70 [UNKN						abeth		arris	
Mar	12 sh h and 7 le m treum		19a. Informant's Name/Relationsh	_	an				or Rural Route Number., Baltimo	-	State, Zip Code) 21214	
	1 and 2 Health 16m 27		Derrick Arter 20a. Method of Disposition	Grands	20b. F	Place of Dispo	osition (Name of	!	Date		City or Town, State	
OL.	Pages nent of int: If it		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		ite		matory`or other pi em. Park		-14-05	Randa.	llstown, Md.	
Baltimore	permit. Pages 1 ar Department of Hea Importent: If Item any injury or othe once.		21. Signature of Funeral Service L	icensee			2. Name and Add	-		ltimore	, Md. 21202	
<u>m</u>	99 = 99		Draft Mil	-			March 1			L E. Nor		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	sed the deat n line.	h. Do not en	ter the mode of dy	ring, such as c	ardiac or respiratory	arrest,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a M	10C		il r	ntar	ctuon		1 day	
	Examiner			Due to (ork	as a consec		1 Act	un	Dise	ie	15 we	,
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a conseq	juence of):)	-)			1 3	-
V	cate be executed physician and the burial-transit	Examiner	that initiated events	c. +	TN						20 975	
90,	oe exe	i Ex	resulting in death) Last	Due to (or	as a conseq	quence of):						
8760	cate b physic the b	dicai		d								
9 xc	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Da	te of delivery	
. Box	that the death hed by the atter detached for u	iciar	in the past 12 months?	1☐Live birth	t at time of c		□Ectopic pregnan □ Other (s <i>pecify)</i>	cy		Mo	onth Day Year	
P.O.	at the by th	hys	9 Unknown	9□ Unknow					1 24			
	9 <u>5</u>	by	Part II. Other significant condition		h but not res	sulting in the u	inderlying cause of	given in Part I.		tobacco use cont]Yes 2 □ No	tribute to the cause of death? 3 Probably 4 Unknow	m
orc	w requir been si should	eted	<i>V</i> (7)	1 17 - 3	Ü	0.	2 (1)	1/22	24a. Wa		Were autopsy findings available	
Rec	has b	Completed							auto	opsy formed?	prior to completion of cause of death?	
Vital Records,	en: Ti ifficate or, pa	e Co	25. Was case referred to medical			-		26. Place	1 ☐ Yes of Death (Check only		1 ☐ Yes 2 No	
ί	Phyeicien: rthis certific ral director,	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 🗆 Inp	atient 2	ER/Outpatie	nt 3 DOA	Whor	V	sidence 6 Oth	ner (Specify)	
	ng Ph fter th ineral		27. Manner of ✓ ath 1 Natural 5 ☐ Pendin	28a. Date of I (Month,	njury Day Ye <i>ar)</i>	28b. Time of Injury	W	ork?		how injury occur	red	
Sio	tendi Jeath. tor: A the fu	cati	Accident investig	gation	Inium. At h	ome form at		□Yes 2□N		(Street and Numb	per or Rural Route Number,	_
Division of	after after Direction by	ertif	4 Homicide determ	ined 288. Flace of building	, etc. (Speci	fy)	reet, factory, offic	e		own, State)	or ribrar ribate variable,	
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical Certification:		g Physicien: To the be								
	the Ho	ledic	one)	and manner	s or examina stated.	ation and/or in			n occurred at the time		and due to the cause(s)	
	Vith To COT	2	29b. Signature and title of certified	15 moto	1ane	_/	29c. Lice	nse number	c	29d. Date signe	d (Month, Day, Year)	
	^		20 1000	W /	of dooth (1)	2	Print\	101) (عامار	16,600))
	8		30. Name and address of person Matthe w	4 .	of death (Iter		940 E	- ter	2 Ave	BRAX	0 MO 2122	1
¥	Sta		31. Date filed (Month, Day, Year)	2005 32. 209	istrar's Sign	ature	/					
300	Registi	ar	00L 1 4	2003	sur,	B. 1	marke					

			1 - For State Registrar	•		nd / Depa		t of H	lealth a	and M	lental Hyg			23013
			Decedent's Name (First, Middle	a, Last)	-					-	2. Date of Deat	h	100	3. Time of Death
	Physic		Wade		Ha	ayes					July July	Day	2005	5:00PM
	/Medi Examir		4a. Facility Name (If not institution	, give street and numb		ay co	4b. City,	Town, or	Location	of Death	9	4c. Co	unty of Death	
1			J.H.H. Elder	Care			S	parr	ow Po	int			Balti	lmore
I	Funeral Director		5. Social Security Number 226–18–7067	6. Sex 7. 1 ★ M 2 ☐ F	Age (In yrs. 85	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 8-2-1		9. Birthp Cour	place (State or Foreign htry)
	pus w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	0d. Inside City Limits
	e Maryla 8a-f shor	ctor	Md.	Baltimore		Sparro	w Poi				****			1 Y Yes 2 □ No
	th with the	al Dire	10e. Street and Number 2829 Lodge Fa	arm Rd			10f. Żip	212	19		1	0g. Citizen US	of What Cour SA	ntry?
980	be filed within 72 hours after death with the Maryland tal Hyglene. Identify then "natural" or items 23a or 28a-1 show event, If a M. afcal Ex. Interivante notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceded Armed Forcied 1 Tyes 2 If Yes, Give Year or Date	es? [X No		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: B	
21215-0036	nin 72 ho In "natur M. Jieal	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed)	or 5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired	ation during mos	t of worki	ing		of Business/Ind	dustry
212	d withi giene. er than	mo:	3rd grade	College (1-4	01 34)	Labo	orer					Va	aries	
Maryland	S should be filled withir and Mental Hygiene. Is marked other than aumatic event, It e M	To Be (17. Father's Name (First, Middle, Arthur	Last)	Ha	ayes			18. Mothe		(First, Middle, M	Maiden Sur	name) Dixon	
lary	2 6 50	Г.	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	I Route Number,	City or To	wn, State, Zip	Code)
	s 1 and 3 f Health item 27 other tra		Joe Hayes	Son	1001 5				ne Av		Baltimor			
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)			Place of Dispo cemetery, crer oshell	natory or of	her place	den	7–16			on-City or To Lk, Md.	
Balt	permit. Page Dependent of Important: If any injury or once.		21. Signature of Funeral Service	Licensee		22	Name and March				Baltimo 1101 E	re, No.	Md. 21 oth Ave	.202
	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if a my leading to min adiate cause. Enter Underlying Cause (Disease or injury that initiated events	a Due to (uence of):		of dying	g, such as	cardiac o	r respiratory arre	est,	2	Approximate Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medicai Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	1 2 ∏ Fetal t at time of de	incy	Ectopic pre					23d.	Date of delive Month	rry Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant condition	ns contributing to deat	h but not resi	ulting in the ur	nderlying ca	use give	n in Part I.			acco use c		ably 4 Unknown
of Vital Records,	The law requir ate has been si page 2 should	ompleted	dement	re,	ar H	rrc+	ંડ				24a. Was ar autopsy perform	,	prior to con death?	osy findings available appletion of cause of
ita		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only one			
<u>></u>	S S	2	1 ☐ Yes 2 200	Hospital: 1 ☐ Inp		ER/Outpatien	t 3 🗆 DO	A Othe	r: 4□ Nu	rsing Hor	ne 5 🗆 Reside	nce &	Other (Specify	Asit'd
O L	ding Ph th. After thi funeral	on:	27. Manner of Death 1 Death 5 ☐ Pending		njury Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe ho	w injury oc	curred	Ting
Division	l or Attending after death. Director: After I in by the fune	ertification;	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place of	Injury · At ho	ome, farm, stre	M eet, factory,		′es 2 □ l		28f. Location (Str City or Town,		ımber or Rurai	Route Number,
۵	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	0	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the be examiner: On the basi	est of my know	wledge, death	occurred a	it the tim	e, date and	d place, a	and due to the ca	use(s) and	manner as sta	ated.
	Fo the H vithin 24 Fo the F complete	Medical	29b. Signature and title of certifier	and manner	stated.		29c.	License	number		29	d. Date sig	gned (Month, L	Day, Year)
	7		30. Name and address of person	who completed cause of	of death (Item	23a) (Tuna	Print\	D 4	57.	57	3	aly	, 12.	21224
	8	Name of Street	M M C N E 31. Date filed (Month, Day, Year)	Lieu	497	123a) (Type, 1	- 6- 5 t	ter	~ /	Ave	- Ba	14,1	us	21224
š.	Sta Registr		JUL 1 4	2005	See 1	ture	ale							

			_ FOI	partment of Health and Mertificate of Death		2005 23014
	. Dhuaisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physici /Medic		Richard Grant Hogan Jr.		July 11,	2005 11:20p M
	Examin	er	4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice	4b. City, Town, or Localion of Death Baltimore		4c. County of Death N/A
\$. Funeral Director		5. Social Security Number 215-24-9550 6. Sex 7. Age (In yrs. last birthda Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Maryl f sho	tor	MD N/A Baltimo	X O		1 No Yes 2 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	100	J. Citizen of What Country?
	th with	alD	1434 Forest Park Ave.	21207		USA
	lems lems	Funeral	Armed Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural; or items 23s or 28a-1 show other traumatic evant, the Medical Evanties must be notified at	by Fi	1 □ Never Married 2 □ Married 1 □ SYYes 2 □ No If Yes, Give 3 □ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: White
9	2 hou	ted	15. Decedent's Education 16a. De	cedent's Usual Occupation	ing 16	Sb. Kind of Business/Industry
215	ithin 7 ne. nan "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of work . DO NOT use retired)	mg .	Dant Office
121	iled w lygier her th		2 PO	stal Worker	e (First, Middle, Ma	Post Office
Maryland 21215-0036	d be f antal h ced ot	To Be	Richard G. Hogan Sr.		E. Kind	
ary	2 should be f and Mental I Is marked of raumatic eva	Ĕ		iling Address (Street and Number or Run		
	and 2 salth a n 27 is er tra			Box 466 Jefferson		5
altimore,	ges 1 of He if itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	rematory or other place)		oc. Location - City or Town, State
ij	t. Pag ntmen ntant:		`4 □Donation 5 □Other (Specify) Loudon	Park Cemetery 07/18		Baltimore
Ba	permit. Pages 1 Department of H Important: If Ita any injury or ot		21. Signature of Funeral Service Licensee	22. Name and Address of Facility I 3620 Wilkens Ave.		rk Funeral Home ore, MD 21229
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heartfailure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	t, Approximate Interval Between
	Prysician.		Immediate Cause (Final disease or condition			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a conservence of):			
		e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
V	outed id ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause Cisease or injury that initiated events c.			
ĵ,	cate be executed physicien and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760,	cate be executed physicien and the burial-transit	dlcal	d			
9 XC	death certific e attending p ed for use as	Physiclan/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
. Box	death e atter	iclar	in the past 12 months? 1 Ves. 2 Ne.	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
P.O.	the y th	Phys	9 Unknown		as Pidulia	and the second of death 2
	es gu	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	12 Yes	cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 □Unknown
Sor	w requir been si should	etec			24a. Was an	24b. Were autopsy findings available
Vital Records,	о <u>г</u> е	Completed			autopsy performe	prior to completion of cause of
ita	ician: Th certificate rector, pag	ø	25. Was case referred to medical	26. Place of Deat	1 Yes 2 h (Chack only one)	2100
of V	S Si	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat			
on C		lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injur		28d. Describe how	injury occurred
Division	Attan deat ctor: y the	flcat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,			et and Number or Rural Route Number,
ā	s after al Dirac	Certification:	4 ☐ Homicide building, etc. (Specify)		City or Town,	Srate)
	To the Hospital or Attant within 24 hours after deatl To the Funaral Diractor: completely filled in by the	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date	e and place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type 13b. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature	29c. License number	290	1. Date signed (Month, Day, Year)
			1. Ph_ M.O.	D1300	6	7/12/05
	5		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	0 //	M 1 7 1 2 6 1
	0	10	31. Date filed (Month, Day, Year) 32. Registrar's Signature	read st.	130/to	[/"Id , 20]
	Sta Registr		JUL 1 4 2005 James & A	are)		

At Known AS: Polly Herman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N.2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** HERMAN 7:49 PM POLLY July 12 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Baltimore N/A Hospital of Belti more Simai If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
MAY 13, 1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2QF Months Yrs. 84 **ENGLAND** Director 579-62-6449 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State "neturel", or items 23a or 28e-f show 1 ☐ Yes 2 🙀 No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21209 USA 2517 SUMMERSON ROAD Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2121 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **TEACHER** EDUCATION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be marked LEHMAN BORSTEN DORA SAMUEL 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2517 SUMMERSON ROAD - BALTIMORE, MD 21209 item 27 I MILTON HERMAN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State ERETZ HACHAIM CEM. 07/14/12005 MIFGASH SHAMSON, ISRAEL ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatur Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Rupture Hortic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unseas or injury Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year in the past 12 mor Month Day 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 1 ☐ Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 → ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 2 No After this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director; 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t hours efter 4 Homicide To the Hospitel of within 24 hours of To the Funerel D completely filled in 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier D59062 July 12, 2005 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Baltimore J. Hansen M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:30A M 11,2005 July. Elinor Ruth Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Severna Park Anne Arundel Sunrise Assisted Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 23, 1934 Birthplace (State or Foreign __Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 □ **X**F Min. Hours Months Days Vermont 009-24-7361 **Director** Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-1 show other treumetic event, the Madical Examinar must be notified at 1 Yes 2 No Directo Proctor Proctor Vermont 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 05765 United States 59 Warner Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Item any injury or other treumetic event, the Medical Exemples. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕱 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) New England Medical College (1-4or 5+) Elementary/Secondary (0-12) Director of Physical Therapy Center 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Kinne George Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1406 Ridgeway East, Arnold, Maryland 21012 Mrs. Heidi Hammel 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 7/18/05 Evergreen Cemetery Rutland, Vermont ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tossing Funeral Home, Inc. 39 Washington Street, Rutland, Vermont 05701 M01113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** aterne Smorths Sarcoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 NO 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 200 No 1 ☐ Yes the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 2 1 Tes After this funeral di 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Manner of Death 28b. Time of 1. Natural 5 Pending death. 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ hours after 4 | Homicide within 24 hours a Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 052830 lenine weins MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road #300 Annapolis, MO /0 leanine werner 900 Bests 31. Date filed (Month, Day, Year) JUL 1 4 2005 32. Egistrar's Signature State Registrar

Mileiner, Anna Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please 1 - State Registrar	Type or Prin State of Ma		Departr		alth and I	Mental Hy	_	ole.
Physic /Medi Exami	dal.	Decedent's Name (First, Middle, Las Anna G. Kleiner 4a. Facility Name (If not institution, give			46.	. City, Town, or L	ocation of Death	2. Date of De Month		Veal 2 Time (1) of th 7
Funeral Director		5. Social Security Number 5. Social Security Number 6. Security Number 1	PX HOSPI PX 2X F 83	(In yrs. last b	oirthday) If Mo	Rose Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Pa April 19	, 1921	9. Birthplace (State or Foreign Country)
e Maryland 8a-f show	ctor	Usual Residence of Decedent 10a. State Md. Baltim	ore	-	own or Location			**************************************		10d. Inside City Limits 1 ☐ Yes 2X No
h with the	ai Dire	10e. Street and Number 2614 Liberty Pa	rkway		10	Of. Zip Code 21	222		10g. Citizen of W USA	hat Country?
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-1 show any in ury or other treumatic event, the Medical Evaruit er must be netitied at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		ŀ	Decedent of Hisps, specify Cuban, Yes 2X No	panic Origin? (Si Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		- American Indian, k, White, etc. White
within 72 ho iene. then "netur	Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5-	+)	(Give kind	s Usual Occupation of work done during the second of the s		king	16b. Kind of Bus	siness/Industry
Jould be filed Mental Hygi harked other	To Be Co	17. Father's Name (First, Middle, Last) Michael Ruth				1	Bertha	Kelch	Maiden Sumame	
and 2 shealth and 127 is n		19a. Informant's Name/Relationship (7 Gary Kleiner	son	18		effield		Joppa Md	ar, City or Town, S . 21085	state, zip Code)
Pages 1 ament of He ent: If item ury or oth		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Specify)	20b. Place cemet Oak	of Disposition tery, cremator Lawn C	(Name of y or other place) LeM.	July	^{Date} 7 16, 2005	20c. Location - 0	City or Town, State
permit Depart Import any in		2 Signature y uneral Service Lice	sel		Conn	me and Address elly Fur Sollers	neral Ho	me Of D		
Physician /Medical-		23a. Part 1 Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line	Mary	o not enter the	e mode of dying,	such as cardiac	or respiratory ar		Approximate Interval Between Onset and Death 3 CLAUS
be executed sicien and purial-transit	icai Examiner	Sequentially list conditions. If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as a c. Due to for as a d.	consequence	to 5	epsis	lavicay	s fiss	inla	10 days
The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal dea		opic pregnancy er (specify)			23d. Date Mon	of delivery th Day Year
w requires that been signed be should be deta	by	Part II. Dther significant conditions co	ontributing to death bu	t not resulting	in the underh	ying cause given	in Part I.			bute to the cause of death? 3 Probably 4 Minknown
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nysician: Th	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/0	Outpatient 3	DOA Other:		th <i>(Ch</i> eck o <i>nly o</i> ome 5 ☐ Resid	ne) lence 6 🗆 Othe	r (Specify)
Attending Physician: or death. ector: After this certific by the funeral director,	Certification:	27. Manner of Death 1		Year) ry - At home,	. Time of Injury A		t s 2 □ No			r or Rural Route Number,
To the Hospital or Attandin within 24 hours after death. To the Funerel Director: Att completely filled in by the fur	Medical Cert	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of inner: On the basis of	f my knowled				, and due to the	cause(s) and man	
To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stat	ed.		29c. License r	number		29d. Date signed	(Month, Day, Year)
		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type Print	223	3438	1,41,4	July	12,2005
Sta Regist		31. Date filed (Morith, Day, Year) JUL 1 4 20	a ras 9	r's Signature	Spark	in low	are Dr	ive,	2 Fimo	ore M. 1.37

			. For	State of Maryla	nd / Depa	rtment of H	ealth and M	•	•	ie.
_			State Registrer		Cer	tificate of l	Death		g. No2 () ()	5 23018
	Physici	ian	1. Decedent's Name (First, Middle, Last) Mary Emma Kaitis					2. Date of Death Month	Day Y	ear 3. Time of Death
	/Medi		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Death	2017	4c. County of	
	Examir	ier	North Arundel Hosp			Glen B			Anne Ar	rundel
Ė	Funeral		Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9	Birthplace (State or Foreign Country)
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7	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loc	ation				10d. Inside City Limits
Ja Ja	with the Maryland a or 28a-f show	ō	MD Anne Arur	ndel Je	essup					1 ☐ Yes 2 X No
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	r dea	Iner	11. Marital Status 12	. Was Decedent Ever in Armed Forces?	U.S. 13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36	hours after tural', or its	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		☐ Yes 2X No	Specify:		Specify:	white
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	72 hours after death with the Marylar 72 hours after death with the Marylar "natural", or Items 23a or 28a-f show died Examinational Legisland	edt	15. Decedent's Educa	tion	16a. Deced	ent's Usual Occupa	ation furing most of worki	10	6b. Kind of Busin	ness/Industry
7	within 72 ene. then "nat	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give k	and of work done of O NOT use retired	furing most of worki)	ng		,
77 8		Com	12		Se	cretary			Own Bus	
7 6	12 should ba filed within and Mental Hygiene. Is marked other then "raumatic event, the Mes	Be	17. Father's Name (First, Middle, Last) Benjamian Franklin	Tonta			18. Mother's Name	<i>(First, Middle, M</i> th Glass	aiden Sumame)	
A A Sarvland	nould 1 Men narke	၉	19a. Informant's Name/Relationship (Type	N In the Contract of the Contr	10h Mailin	Address (Carest	and Number or Rura		City or Town Ctr	ata Zin Cada)
2	permit. Pages 1 and 2 should be illed Department of Health and Mental Hyg Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumattic event, and ce.		Ruth Lurz - daughte		1		eo Road, C		-	
2	s 1 ar f Hea item other		20a. Method of Disposition	20b.	Place of Dispos					ty or Town, State
Baltimore	Page nent o int: If		1X Burial 2 □ Cremation 3 □ Ren 1 4 □ Donation 5 □ Other (Specify)			Mem. Cer		/2005	Abingd	lon, MD
<u>=</u>	permit. Departingorta Importa any inju		21. Signature of Funeral Service Licensee		Gar	Name and Addres	s of Facility	ral Home	. 0 Meadox	wridge MP, Inc.
<u>~</u>	82588		MIM		1/25	U_Washin	aton Blvd	. Elkri	dae, MD	21075
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the dea cause on each line.	ath. Do not ente	r the mode of dying	g, such as cardiac o	r respiratory arres	it,	Approximate Interval Between Onset and Death
	Physician /Medical	7	Immediate Cause (Final disease or condition resulting in death)	Myoc	ardi	al 1	n force	tion		4 days
	Examiner			Due to (or at a conse	1		12 0	orrhad		5 days
	ey Sal	ē	Sequentially list conditions, if any, reading to immediate	Due to (or as a const		neal	nem	OII MAG	12	3 1/2
(cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
0	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):					
68760	cate b	dicai	d							
9	ding p	Physician/Medi	IF FEMALE: 23c	. If yes, outcome of pregr	nancv				23d. Date of	of delivery
Вох	atten atten	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fel 4 ☐ Pregnant at time of	tal death 3 1	Ectopic pregnancy Other (specify)			Month	,
P.O.	the d by the ached	hysi	9 Unknown	9□ Unknown						
	uires that the densigned by the a	by P	Part II. Other significant conditions contri	buting to death but not re	sulting in the un	derlying cause give	en in Part I.	23e. Did toba		ute to the cause of death?
rd	w require been sig should b	ted	Carcinom	a rig	ht	12 id	ney	1 🗆 Yes	2 1 1 6 3	☐ Probably 4 ☐ Unknown
Division of Vital Records.	The law requires that the death certificat steep has been signed by the attending phypage 2 should be detached for use as the	Completed	A6domiual	corti	<u> </u>	cheur	ysm	24a. Was an autopsy	prior	re autopsy findings available or to completion of cause of
<u> </u>	sician: The law scertificate has b lirector, page 2 s	Con					1	performe		Yes 2 No
Ž.	ilcian certifi rector	Be	25. Was case referred to medical examiner?	spital:		aCI DOA Othe	26. Place of Death			
ō	Phys	. To	1 Yes 2 BARO	28a. Date of Injury	28b. Time of	28c. Injury	at 2	ne 5 Residen		Specify)
0	nding tth. :: Afte e fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆 Y	:? /es 2 □ No			
N. S.	Atteller dear dear dector	Certification:	a Could not be	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre	et, factory, office	2	28f. Location (Stre City or Town,		or Rural Route Number,
	Ital o	Cer								
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director; After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exeminer	ian: To the best of my kr r: On the basis of examin and manner stated.	nowledge, death nation and/or inve	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the cau ed at the time, date	se(s) and manne e and place, and	er as stated. I due to the cause(s)
	o the orthe omple	Mec	29b. Signature and title of certifier	and marmer stated.		29c. License	number	290	1. Date signed (N	Month, Day, Year)
	F \$ F 0		1/10 5	Culin	- mo	03	1478)		5014	08 7007
	,		30. Name and address of person who comp	oleted cause of death (Ite	om 23a) (Type, P	rint)	harles	E (11/0)	इस्प	Glen Burnie MD
_	4		Baltimore Wa	shinton	Medica	1 Cen	ter 30	Hognit	21 Dr. (Jen Burnie MI
	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 4 200	32. Ragistrar's Sign	lature	anti s		U		
	9.00		10 L T # 500	LEE SELLE	10 190					

			. For	partment of Health and Me ertificate of Death		2005 23019
	Physicia	an	1. Decedent's Name (First, Middle, Last) Catherine W. Lee		2. Date of Death Month D	ay Year 5:19 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	Examin		Union Memorial Hospital	Baltimoe		N/A
	Funeral Director		5. Social Security Number 6. Sex 1 M 2007 7. Age (In yrs. last birthda 73 Yrs.	Months Days Hours Min.	B. Date of Birth (Month, Day, Yea Ct. 24, 1	9. Birthplace (State or Foreign Country) 931 Kentucky
]	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation		10d. inside City Limits
	a-feh	ctor	Maryland N/A Balt	imore		1 ∑ ★es 2 □ No
3	or 28	Funeral Directo	10e. Street and Number	10f. Zip Code 21211	10g. C	itizen of What Country?
	eath v	erai	3939 Roland Avenue Apt. 802 11. Marital Status 12. Was Decedent Ever in U.S. 13		ify Yes or No-	USA 14. Race - American Indian,
9	atter or iten or iten		1 Never Married 2 Married 1 Yes 2∑No	. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 ☑ No Specify:	ićan, etc.)	Black, White, etc.
003	ural',	d by	3€ Yes, Give Year or Dates:		101	Specify: white
21215-0036	"nat	Completed	(Specify only highest grade completed) (Gin	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	g 16b.	Kind of Business/Industry
212	giene. grenthar	Com	Elementary/Secondary (0·12) College (1·4or5+) Certi	fied Nursing Assist	ant	Health Care
Maryland	shoud be lied within 72 hours atler death with the Maryland ind Mental Hygiene. The Watch Hygiene marked other than "natural", or items 23s or 28s-1 show imetic avent, the Madical Exeminer must be notified at	To Be (17. Father's Name (First, Middle, Last) Floyd Whitaker	18. Mother's Name (n Sumame)
Mary	2 6 6 6		1 1 1 1	iling Address <i>(Street and Number or Rural)</i>) W. 40th Street Ba		
ē.	s 1 and it Health Itam 27 other ti		20a. Method of Disposition 20b. Place of Dis	position (Name of Date ematory or other place)		Location - City or Town, State
<u> </u>	Page ment c ant: If ury or		1 Bural 2 Octemation 3 Hemoval from State 4 Donation 5 Other (Specify) Baltimor	re-Washington 7/15/		urel, Maryland
Baltimore,	permit. Pages 1 and Department of Health Important: If Itam 27 any Injury or other tr		21. Sign fur of Funeral Service Livens	22 Name and Address of Facility Burgee—Henss—Seitz 3631 Falls Road Ba	Funeral H ltimore,	ome, Inc. MD 21211
F	nysician _i		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one caus on each line. Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (ir as a cons, quence of):	1.		30/
	Zammei	er	Sequentially list conditions, if any, luading to instructed cause. Enter Underlying Cause (Disease or injury)	AGIS		iohrs
	cuted	Examiner	that initiated events c. I'VI COV OUVILLIAM	farction		Ichri
760,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
687	physi s the	edicai	d	79-19-19-19-19-19-19-19-19-19-19-19-19-19		
X	eath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
B	I ne law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M		Other (specify)		Month Day Year
J	mar in		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds	w requires mar been signed t should be deta	leted by	HTN, Parotypend A. Fib, ch	one powereatitis	1 🗆 Yes	2 No 3 Probabiy 4 Zunknown
Records,	law re as bee	plet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
		Compl			performed?	death? 1 Yes 2 No
Vital	scertificate	o Be	25. Was case referred to medical examiner? 1 Test 2 No Hospital: 1 Inpatient 2 ER/Outpat	26. Place of Death (ent 3□ DOA Other: 4□ Nursing Home		6 □Other (Specify)
Division of	aing rnys h. Atter this funeral dii	-	27. Manner of Death 1. Natural 5 □ Pending (Month, Day Year) 1. Natural 1. Pending (Month, Day Year)	of 28c. Injury at 28 Work?	8d. Describe how inj	
1810	death. ctor: A y the fu	ficati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	M 1 ☐ Yes 2 ☐ No		and Number or Rural Route Number,
2	rafor safter al Dire	Certification;	4 Homicide determined building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, Sta	te)
	to the trospinal or Attending Priystcian: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my knowledge, de 2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	nd due to the cause(d at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
,	To t To t com	M	29b. Signature and title of certifier MD	29c. License number AT 2438946	29d. D	ate signed (Month, Day, Year)
	4		30. Named and address of person who completed cause of death (Item 23a) (Typ FLORELLO SVEN-ERIK QUIANZON L	Inum Memoral Hospita	1. Baltima	e, MD 21218
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 4 2005	(e)		

			1- For State of Maryland /		artment of H		lental Hy	giene Reg. No	חחב	22220	
	Physic		1. Decedent's Name (First, Middle, Last) Kenneth Wayne Lamkin				2. Date of De Month July	eath Day	005 Year	9:30 P M	
	/Medi Examii		4a. Facility Name (If not institution, give street and number) Long Green Center 115 E. Melrose	Location of Death	- u2)		County of Death				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 15-78-2871 1. Sex 43	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Or Sept 22	ay, Year)	Coun	lace (State or Foreign try) 1and	
	Maryland f show	lor	Usual Residence of Decedent 10a. State 10b. County 10c. City, To Maryland N/A		ocation timore				10	0d. Inside City Limits XXYes 2 □ No	
	h with the 3a or 28a	Funeral Director	10e. Street and Number 705 W. 37 th Street		10f. Zip Code	21211		10g. Citizen of What Country?			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, the Medical Eventiral must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - America Black, White, e Specify: Whi	etc.	
21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11	(Give	DO NDT use retired	during most of worki	ing		d of Business/Ind	lustry	
land 2	uid be filed fental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Richard C. Lamkin, Sr.			18. Mother's Name Grace L			lumame)		
, Maryland	and 2 shore ealth and N m 27 Is mana		Grace L. Lamkin Mother	43 Newpor	and Number or Rura t Avenue	Baltin	nore,	Marylan	d 21211		
Baltimore,	t. Pages 1 tment of H tant; If Itel		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) **Common State** **A ☐ Donation 5 ☐ Other (Specify)	tery, crei	osition (Name of matory or other plac rematory	7/13	/2005		ation - City or Tov onsville	wn, State , Maryland	
Bal	Departing Many In		21. Signal Funeral Service Licensive 23. Part I Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.]	2. Name and Address Burgee-He 3631 Fall er the mode of dvice	nss-Seitz s Road, B	Funera altimo	al Hor re, Ma	me, Inc. aryland	21211 Approximate	
8760, <	/Medical Examiner bhysician and streaminer sthe burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the condition of the cond	e of):	w meter	1.549515	18 pc	-10	-	waynews	
O. Box 6	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	23	23d. Date of delivery Month Day Year						
ords, P.	equires that is an aigned by ould be deta	by	Part II. Dther significant conditions contributing to death but not resulting		Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown						
Division of Vital Record	: The taw r cate has be page 2 sh	Completed					24a. Was autor perfo 1 Yes		24b. Were autop prior to com death? 1 \(\text{Yes} \) ?	osy findings available inpletion of cause of 2 No	
Ħ	alciar certificacto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/C		nt 3 DOA Othe	26. Place of Death			☐Other (Specify)		
ion of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	\vdash	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	. Time of Injury	f 28c. Injury Work		28d. Describe				
Divis	ospital or Atte hours after de ineral Directo y filled in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)				City or To	wn, State)	Number or Rural		
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death and/or in	occurred at the tim vestigation, in my op 29c. License	pinion, death occurre	ed at the time,	date and p	nd manner as sta lace, and due to signed (Month, D	the cause(s)	
	- X X - O		29b. Signature and title of certifier) (Tue-	Doos	59056		1	Ll os	-,,	
		to.	30. Name and address of person who completed cause of death (Item 23a	1) (Type,		MT Roge	1 Ave	B	=1+ MO	21217	
DHI	Sta Registr MH 17 Rev 1/2	ar	JUL 1 4 2005 Recen # 19	IGINA	S.L.						

			For	State of Maryland				Mental H	ygiene			
			1 - State Registrar		Cert	ificate of	Death	To Day of	Reg. No.	2005	23021	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) CHARLES			LUN	ΓZ	2. Date of I Month JULY	12 Day	2005 Year	3:20 A M	
	Examir		4a. Fecility Name (If not institution, give st RUXTON PIKESVILL				or Location of Deat SVILLE	th	4c. County of Death BALTIMORE			
	Funeral Director		5. Social Security Number 6. Sex 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	t birthday)	If Under 1 Year Months Days			9. Birthplace (State or Fore Country) MD				
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loca	ation				10	Od. Inside City Limits	
	ath with the Marylar 23a or 28s-f ehow ust be natified at	tor	MD BALTIMORE	BALT	IMORE					1 ☐ Yes 💥 ☐ No		
	or 28s	Director	10e. Street and Number			10f. Zip Code			_	10g. Citizen of What Country?		
	ath w		7 SUDBROOK LANE	. W. D	1 12 14	212		Specify Ven as I		U.S.A. 14. Race - American Indian,		
920	72 hours after death with the Maryland natural', or Items 23a or 28s-f show alcel Exemitrer mast be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cul	Hispanic Origin? (Span, Mexican, Puer Specify:	1	Black, White, o	etc.		
5-0	72 hours "netural",	eted	15. Decedent's Educ (Specify only highest grade		(Give k	ent's Usual Occu	during most of wo	rking	16b. Kii	nd of Business/Inc	lustry	
21215-0036	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	SALES	O NOT use retire MAN	90)		C	LOTHING		
pu	othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Mida	le, Maiden			
Maryland	should by ind Menta marked umatic ev	To	HARRIS	0.11	LUN		LENA				HUTZ	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type PAULINE LUNTZ /		-		tand Number of R GLEN DRIV					
Baltimore,			20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re	moval from State	netery, crema	tion (Name of atory or other pla		Date		cation - City or To		
Ħ			* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lightser				REIN 07/1			EDALE, MI		
Ba	permit. Departr Imports eny inj		Law Mande	^			STERSTOWN					
£	Physician	8 0	23a. Pan f. Enter the disease, or complic shock or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death cause on each line.	Do not enter	the mode of dy	as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ng of):	00	7	11 -				
		er	Sequentially list conditions, is any, leading to immediate	Olie to (or es a consecue	CUMV	uny c	meny	Asea	se			
	acuted ind transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events cut	Due to (or as a conseque								
8760,	cate be executed physician and the burial-transit		resulting in death) Last	nce of):								
687	ificate g phys as the	edical	d.	•/~ : *** ; =::=								
Вох	death certific e attending p id for use as f	Physician/Me	23b. was decedent pregnant		Petal death 3 Ectopic pregnancy					23d. Date of delivery Month Day		
o.	0 0	ysic	250. Was decedent pregnant in the past 12 months? 1									
ds, P	es pe	by	Part II. Other significant conditions cent	ribyting to death but not resulti	ing in the und	derlying cause g	iven in Part I.		tobacco u	se contribute to th □No 3□ Prob		
Vital Record	aw S S	Completed						24a. W	as an	24b. Were aulop	osy findings available	
E E	The ate h page	Com							formed?	death?		
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	2/0	000	26. Place of De				,	
o	g Phys er this	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ EF 28a. Date of Injury (Month, Day Year)	8b. Time of	3☐ DOA 28c. Inju		28d. Describ		S □Other (Specify y occurred)	
sior	Attanding Ph r death. ector: After th by the funeral	atio	1 Natural 5 Pending 2 Accident investigation	(Worth, Day 16ar)	Injury		Yes 2 No					
Division	or At or At or A or A or A or A or A or A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location City or 7	(Street and own, State)	d Number or Rura.)	Route Number,	
	To the Hospital within 24 hours a To the Funeral (completely filled	edical	(Check only 2 Medical Exprin	cian: To the best of my knowledger: On the basis of examination	edge, death on and/or inve	occurred at the lestigation, in my	time, date and plac opinion, death occ	e, and due to thurred at the time	e cause(s) e, date and	and manner as st place, and due to	ated. the cause(s)	
	To the within 2 To the Comple	Med	29b. Signature and title of certifity	and manner stated.		29c. Licer	se number		29d. Date	e signed (Month, L	Day, Year)	
)	->-0		▶ Kth	, Mi)		n	2756	9	1	7/12/0)	
1			30. Name and address of person who cor	npletedicayse of death (Item 2		rint)	6500	. 0 -	101	RI	2/208	
~	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	run re L	10 28	orea	ne I	vec	10		
	Registr	ar	1111 1 / 2	NOT MARKET	D 4							

			For State Registrar	State of	Maryland /		artment <i>rtificate</i>			and M	ental Hy	gien Reg. N	2000		23022
	Physici		1. Decedent's Name (First, Middle, Margaret Ann M								2. Date of De July 1		2005 Ye	ır	3. Time of Death 11:08 PM
	/Medic Examin		4a. Facility Name (If not institution, 1148 E1m Rd	give street and nun	nber)			b. City, Town, or Location of Death Arbutus				4c. County of Death Baltimore			e
	Funeral Director		5. Social Security Number 219-07-9719 6. Sex 1 M 2 F 83 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.				Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or I Country) 9-6-1921 Maryland			try)				
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore Arbutus											10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the	Funeral Director	10e. Street and Number 10f. Zip Code 1148 Elm Rd 21227									10g. Citizen of What Country? United States			
980	be filed within 72 hours after death with the Maryland nat Hygiene. id other than "natural", or items 23s or 28s-f show event, the Madical Exertirer must be notified at	þ	11. Marital Status 1 ☐ Never Married 2塔 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed For	2 ∰ No e		Was Decede If Yes, specif		panic Oric , Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)	>-	14. Race - A Black, W Specify:	hite, e	
Maryland 21215-0036	d within 72 ho giene. Irr than "natu	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12	s Education grade completed) College (1	40(5)	(Give life.	dent's Usual kind of work DO NOT use Sing G	done du retired)	uring most	t of workin	g		16b. Kind of Business/Industry County Government		
land	d 2 should be filled within h and Mental Hygiene. 7 le markad othar than "traumatic evant, tra Mas	To Be C	17. Father's Name <i>(First, Middle, L</i> Andrew Wallace	ast)							(First, Middle Hauf	, Maide	en Sumame)		
	= ~ .		19a. Informant's Name/Relationsh Charles Metcalf								Route Numb	-	or Town, State	a, Zip	Code)
Baltimore,	Pages 1 and nent of Healt int: if item 2: iry or othar it		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 4 ☐ Donation 5 ☐ Other (Sp				osition (Name matory or oth Cremate				2005		Location - City timore		
Balti	20a. Method of Disposition Section Sectio													-	
Ž.	Physician		23. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause n e	ach line.										Approximate Interval Between Onset and Death
8760,	/Medical Examiner ohysiclen and the burial-transit	dicai Examiner	resulting in death) Society list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	or as a consequence	01).	ARTE	eny	6	015€	=ARC				
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the ettending physicien and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	come of pregnancy irth 2 Fetal deat ant at time of death wn		∃Ectopic pre ∃Other <i>(spe</i> e						23d. Date of Month		y Day Year
Δ.	quires that I n signed by uld be deta	by	Part II. Other significant condition	ns contributing to de	ath but not resulting	in the u	nderlying car	use giver	n in Part I.					to the	e cause of death?
Il Records,		Completed									24a. Was auto perfe 1 🗆 Yes	psy rmed?	prior death	o com ?	sy findings available inpletion of cause of
f Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital:	npatient 2 ER/O	utpatier	nt 3 DOA				(Check only		6 ☐Other (S	pecify)
Division of	al or Attending Ph : after death. i Diractor: After th d in by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation	h, Day Year)	Time o Injury	М	Sc. Injury Work: 1 🗆 Y	at	No 2	8d. Describe	how inj	jury occurred		
Divis	spital or Att ours after de naral Diracti filled in by t	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 280. Place	of Injury - At home, f ng, etc. <i>(Specify)</i>	arm, sti	reet, factory,	office		2	8f. Location (City or To			Rural	Route Number,
	To the Hospital or within 24 hours afte To the Funaral Dirr completely filled in I	Medical	(Check only 2 Medical 8	xaminer: On the ba and mann		nd/ <i>or</i> in	vestigation, i	in my opi	nion, dea	th occurre	d at the time,	date a	nd place, and o	ue to	the cause(s)
	Son Take To	1	29b. Signature and title of certifier	CK.	Qu m	0	29c.	License 03	riumber 363	36	,	3 0	ate signed (Mo)	2005
1	1		30. Name and address of person of Frenericus K	who completed caus	e of death (Item 23a)	(Type,	Print)	A A	ett	= 30	o B	2/17	MOP	N	१० याद
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prepartie Kun m 3445 Willows Are # 300 Bultimore mo 2125 State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature															

State

Registrar

30. Name and address

31. Date filed (Month, Day, Year)

Pamela E Southall, mo

1 4 2005

of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

Registrar

State

G-OURISHANKAR

31. Date filed (Month, Day, Year) JUL 1 4 2005

700A

MAGANNA

2. Registrar's Signature

PODLE RO WESTMINSTER

MD 21157

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Lanie H. Moss July 6, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard 7226 Lasting Light Way If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2XF Months Director 89 407-03-7713 August 7, 1915 Kentucky Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Marylend nent of Health and Mental Hygiene. and if item 27 is marked other than "natural", or items 23s or 28s-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County I il Agiene.
Il Hygiene in atural, or iteme 23a or 28a-f ehow
vent, ite McGral Exeminar must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21045 U.S.A. 7226 Lasting Light Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify If Yes, Give Year or Dates: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Clerical Elementary/Secondary (0-12) College (1-4or 5+) Medical Records 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helen E. Denumberum Charles W. Hurt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health er Important: if item 27 is any injury or other treu once. 7226 Lasting Light Way Columbia, Maryland 21045 Ms. Lorinda Linthicum Neice 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Edmonton , Kentucky ^ 4 □ Donation 5 □ Other (Specify) **Edmonton Cemetery** 22. Name and Address of Facility 23a. Part1. Enfer the disease for complications that caused the death. shock, or heart laintie. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death). Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Physician resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence ol) Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown I signed by the an I. 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the under in course given in by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 2 No 1 ☐ Yes certificate Yes After this certifical funeral director, r To the Hospitei or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manna Certification: Natural 5 Pending Injury efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie Cark Brown vho completed cause Name and address of perso 32. Registrar's Signatur 31. Date liled (Month, Day, State Registrar

Salim Mamadou Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK 05-04106 State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene Control of Death Registrar Registrar Registrar 05-04106 Reg. No. 2 RPD 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** Mamadou 2005 0345 A Salim June 16 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Metro Transit Tracks below Spring Street Silver Spring Montgomery If Under 1 Year If Under 24 Hr 8. Date of Birth Month, Day, Ye March 18, 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 3. 1981 Bangui, **Funeral** Months Days Hours Min 24 Director 212-65-1525 Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10b. Count 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Directo Takoma Park Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Central 20912 7600 Maple Avenue Africa Republic death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ð 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Student Education Pages 1 and 2 should be filed inent of Health and Mental Hyginnt: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Sani Mamadou Lucile Benoua 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvain Tchoudjen (Friend) 3309 Beaver Wood Ln., Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö Department of Important: If any injury or once. Metropolitan Crematory 7/12/05 1 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee-Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Multiple Injuries /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vaar in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \(\subseteq \text{No} \) 24a. Was an autopsy page 2 certificate has 1 Yes 2 🗆 No Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Hame 5 Residence 6 Other (Specify) at scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After June 16,2005 Found: 1 Natural 5 Pending death. 1 Tes 2X No investigation 2 Accident Subject struck by a train or Attences after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Spring Street Silver Spring, Maryland 3 Suicide 4 Homicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

Train Tracks 2 within 24 hours a To the Funerel I 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME

DHMH 17 Rev 1/200

State Registrar

JUL 1 4 2005

Ali

2. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 32. Registrar's Signature

Ta

June 16, 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:59 A M July 9, 2005 Morehead Mills /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 □ M 2 🖾 F 58 Director 244-74-0251 Sept. 1946 North Carolina Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28e-f show in then "neturel", or items 23e or 28e-f show The Wedicul Exercit at must be notified at 1 ¥Yes 2 ☐ No Director NC Guilford Greensboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code WIT U.S.A. # 1 Twinbrooks Court 27407 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other then "neturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Black 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant A&T State University other treumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Morehead Ophelia Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2313 Pattern Bond Dr., Silver Spring, MD 20902 Faye Morehead Knox (Sister) 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: if itel
any injury or ott Carolyina and Bibohar clara 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Gardens July 14, 2005 Jamestown, NC 21. Sign ture of Funeral Service Licenses 22. Name and Address of Facility erry J. Brown Funeral Home 909 É. Market St., Greensboro, NC 27420 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical ue to (ov as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unustying Cause (Disease or injury Examiner as a consequence of) led by the attending physician and detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of); Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 2X□No P.0. 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ should be 2 XV0 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy perfor 1 ☐ Yes 1 ☐ Yes 2 ☐ No I or Attending Physicien: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 3□ DOA 2 2 ER/Outpatient 5 Residence 6 Other (Specify) npatient After this Month, Day Year) 27. Manner of Dath Certification: Matural 2 X A 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No Accident investigation Director: 6 Could not be determined 8 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospitel o within 24 hours at To the Funerel D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30318 me and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr., Cheverly, MD 20785 ames Catavenis, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Blave & Species Registrar JUL 1 4 2005

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** 07/12/2005 1:30 A^M Margaret Mae O'Rourke /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing Home Columbia Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 🗹 F Yrs. Director 92 212-10-2597 05/07/1913 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 1ry or othar traumatic event, the Medical Event and must be notified at 1 Yes 2 XNo Director Ellicott City MD Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 12101 Frederick Road 21042 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Trouser Mfg. Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Seitz Catherine Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104219a. Informant's Name/Relationship (Type, Print) 12101 Frederick Road, Ellicott City, Sandra Saunders/Daughter 20b. Place of Disposition (Name of cometery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Depertment of Important: If It any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 07/14/05 Glen Burnie, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Europal Service Ricensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final :0PD **Physician** obstructive rumovery month disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** HE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit deme morutus and resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. signed by the attending physicien be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Day 4☐Pregnant at time of death 5 Other (specify) 2. No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 tonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2. NO the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 Yes 2 No Other: 4 Durising Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After the Hospital or Attanding I hin 24 hours after death. the Funaral Diractor: After 1. Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified night MD 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 E110 SHAWUNMALA GURTA 9650 SANTIAGO RO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 State	partment of Health and Mertificate of Death	ental Hygie	ene
			Registrer 1. Decedent's Name (First, Middle, Last)	Jillioute of Death	2. Date of Death	1. Not? 0 0 5 2 Timelot Datto
	Physicia /Medic	ian		gundojo	July 6,	Day Year 2005 3:30 P ^M
			4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 0,	4c. County of Death
	Examir	ier	Malcolm Grow	Camp Springs		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
Ш	Director		227-94-5838 1□M 2\\ 1 □ M 2\\ 2 □ F 48 Yrs.	Months Days Hours Min.	(Month, Oay, Y Aug. 13,	1956 Virginia
	pu ,		Usual Residence of Decedent			
	aryla show	_	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 X Yes 2 □ No
	Be-f	ecto	Maryland Prince George's Temple			
	with ti	Dir	10e. Street and Number	10f. Zip Code		g. Citizen of What Country?
	eath na 23	by Funeral Director	4301 23rd Parkway 11. Marital Status 12. Was Decedent Ever in U.S. 13	20748 Was Decedent of Hispanic Origin? (Spe		J. S. A. 14. Race - American Indian.
	ter d	Ľn.	1 Never Married 2 Married 1 Yes 2 No	 Was Decedent of Hispanic Origin? (Spe- If Yes, specify Cuban, Mexican, Puerto F 	Rican, etc.)	Black, White, etc.
036	urs af	by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Black
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28e-1 show the Medical Exam me must be molified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	cedent's Usual Occupation	16	bb. Kind of Business/Industry
21	thin 7	ple	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of workin DO NOT use retired)	'g	
2	ed wi	Con		Cook		Restaurant
nd	tal H d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	1/42-5-1-0	iden Surname)
<u>Y</u>	ould Men Marke Marke	2	George Henry Hamm	Mary Luc		
Maryland	2 sh and is m			iling Address (Street and Number or Rural		
	1 and Healtl			Village Stream Pl.		Oc. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itema 23s or 28e-f show any Injury or other traumatic event. The Mudical Extensing must be notified at ance.		1 🕅 Burial 2 □ Cremation 3 □ Removal from State	ematory or other place)		
ij	rtant njury			ptist Church Cem. 7		The Plains, VA
Ba	Deparmi Departimboo any Ir		21. Signature of the last service Econocc	22. Name and Address of Facility Joynes Funeral Ho		
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	P.O. Box 3633 Wanter the mode of dying, such as cardiac or	r respiratory arres	t. Approximate
				_		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	ry Failure		
	Examiner			***		
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter I Index big. Due to (or as a consequence of):			
V	cuteo nd Iransi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease of injury) that initiated events c.			
760,	ate be executed hysician and he burial-transit	Ë	resulting in death) Last Due to (or as a consequence of):			
876	ate b hysic the b	dicai	d			
x 68	he death certificat the attending phy ched for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			
Вох	attend attend for us	lan	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
o.	he de	ysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	Other (specify)		
Ω.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	H-	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
Records,	juires n sign IId be	d by	End Stage Renal D	115e-se	1 🗆 Yes	2 No 3 Probably 45 Unknown
00	w requires been si	Completed	And Phasabaliaid And	-ibody	24a. Was an	24b. Were autopsy findings available
Re	The lav	mo	THE STATE OF THE S	1300.9	autopsy	prior to completion of cause of death? No 1 Yes 2 No
Vital	alcian: The la certificate ha rector, page 2	BeC	25. Was case referred to medical	26. Place of Death		10 163 20 10
<u> </u>	yalcian: is certifica director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Other		ce 6 Other (Specify)
n of	ding Phy h. After thi funeral		27. Manner of Death 1 ✓ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury		8d. Describe how	injury occurred
siol	endir eath. or: Al	atle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	l or Attendi after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office 2	8f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospitel or Attending Phyalcian: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,		(70.4%)			
	Hosp 24 hor Fune tely fi	Medicai	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one Check on	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	o the ithin 2 o the	Med	29b. Signature and title of contilier	29c. License number	29d	. Date signed (Month, Day, Year)
	⊬ ≯ <u>⊢</u> 8		15/2mm M.D.			7/08/2005
•	.1		30. Name and address of person who completed cause of death (Item 23a) (Typi			
	4		Babak Razi, M.D. 4404 Quee	ashury Kl, Kive	rl-le,	MD 20737
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 4 2005	ente		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY **Physician** 9:30 AN PETERSON, JR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 11630 GLEN ARM ROAD UNIT 26 GLEN ARM If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 12 M 2 □ F Yrs Director 216-14-8756 3/30/1922 MARYLAND Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or itams 23a or 28a-f show the Wedical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director BALTIMORE GLEN ARM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21057 11630 GLEN ARM ROAD UNIT 26 USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 DYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) BGE 4 YEARS MECHANICAL ENGINEER 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be MERVIN L. PETERSON, SR. HELEN DANAHER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) VIRGINIA V. PETERSON/WIFE UNIT 26 GLEN ARM, MD Health itam 27 I 11630 GLEN ARM ROAD 21057 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition DULANEY VALLEY MEM. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If any injury or once. = 6 7/15/2005 COCKEYSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service License 8521 LOCH RAVEN BLVD. TOWSON. MD 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EVERE Immediate Cause (Final disease or condition resulting in death) DUE TO Pnysician /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 182 physician and s the burial-transit be executed Due to (or as a consequence of): Box 68760 Physician/Medical The law requires that the death certificate IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1462 T 1 Yes 2 No 3 Probably 4 Nnknown NAM Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 22 No 1 Yes 2 No 1 ☐ Yes Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 of this 28c. Injury at Work? 28d. escribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To tha Funeral (🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of entifier 200 Name and address of person who completed cause of death (Item 23a) (Type, Print) 12+1 ROS Registrar's Signature Date filed (Month, Dav. Year) State Registrar JUL 1 4 2005

			1 - For State Registrar	State of I	Marylan	-	artment of rtificate o			ental Hy	giene Reg. Ng. (*)	0.0.0	22021
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	/Medi			James Jo		Keynol				suly		2005	324 PM
	Examir	er	4a. Facility Name (If not institution, given Keswick MultiCare		er)		4b. City, Town	or Location [timor			4c. Cc	ounty of Death	h
	Funeral				Age (In yrs.	last birthday)	If Under 1 Yea	r If Under	r 24 Hrs.	8. Date of Birt	h		hplace (State or Foreign untry)
	Funeral Director			1 √ XM 2□F	7	* -	Months Day	s Hours	Min.	(Month, Da) Julv 19			untry) ryland
	p .		Usual Residence of Decedent 10a. State 10b. County		10a Cib	y, Town or Lo	anting						10d. Inside City Limits
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	ems ?	ner	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	S. 13.	Was Decedent of Yes, specify Co	Hispanic Or	rigin? (Spec	cify Yes or No-	14.	Race - Amer Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ant, the Mudical Examinat must be notified at	y Fu	1 ☐ Never Married	1XXYes 2 If Yes, Give Year or Date	□No		I□Yes 2KOXN			,		ecify:	White
8	hour tural	ed b	15. Decedent's E		S: WWII	16a Dece	tent's Usual Occ	unation			16b Kind	of Business/I	
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	od with	Com	11th	College (1-40	JI 34)	Mutu	al Clerk	C			Race	Track	ζ
Maryland	ba file tal Hy d oth	Be	17. Father's Name (First, Middle, Las. James Reynolds	1)					er's Name (dred ((First, Middle,	Maiden Su	mame)	
Z Za	d Men narke	2	19a. Informant's Name/Relationship	(Time Brint)		10b Mailia	a Andreas (Chro	1			. Churt	Ctota 7	Sa Cada)
Ma	d 2 sl th an 27 is r traur		Betty Reynolds	(Wife)			g Address (Stre Edgehi]				-		and 21211
Ğ,	f Heal f Heal item 2		20a. Method of Disposition	, ,	C	lace of Dispo	sition (Name of natory or other p		Da			ion - City or	
E	Pages ient of nt: If if		Magazial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		te Dula	aney V	alley Me	emoria.	1 7/15	5/05	Cocke	ysvill	le, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at some		21. Signature of uneral Service Like	ainer	lu	3	Name and Add Burgee- 631 Fall	ress of Facili Henss- Ls Road	Seitz d Ba	z Funer altimor	al Ho	me, Ir	lc 21211
			23a Part1. Enter the disease, or com shock, or heart failure. List only	plications hat cause on each	sed the death								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	René	il fa	ilevre							3 weeks
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	•						Years
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ó	be executed sician and burial-transit		resulting in death) Last	Due to (or	as a consequ	uence of):							
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9 ×	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outcom	ne of preona	nev					20.4	D-4	
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o.	at the de by the a stached	hysi	1 Yes 2 No 9 Unknown 9 Unknown										
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ō	Phys or this oral di	To To	1 Yes 2 No	28a, Date of Ir	niury	ER/Outpatien 28b. Time of	28c. Ing	4 13 1971		e 5 Resid			ify)
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the be miner: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred at the estigation, in my	time, date an opinion, dea	nd place, an ath occurred	nd due to the c d at the time, d	ause(s) and ate and pla	d manner as ce, and due	stated. to the cause(s)
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	⊢ s ⊢ ō		M Trabelle T	ac ar	egra	00	DI	3657	7		Tuly	12,2	805
	10+1		30. Name and address of person who	completed cause o	f death (Item	23a) (Type, 1	rint) K STREE	E),	BALT			7021	211
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			1 - For State Registrar	State of M	-	epartme Certifica			d Mental H	ygiene Reg. No. 2 (105	22000
	Dhusia		1. Decedent's Name (First, Middle, I	ast)					2. Date of D	eath	Your	3:-Time debeath
	Physic /Medi		Montell		eon		Rob	inson		12,2	005	100 pm
1	Exami	ner	4a. Facility Name (If not institution, g Maryland	General	Hospita	& Be	alti	r Location of E	CYTY		ty of Death	
	Funeral Director		5. Social Security Number 6. 220-74-7443 Usual Residence of Decedent	Sex 7. Ag 12 M 2□F	e (In yrs. last birtho	Month	der 1 Year IS Days	Hours I	Min. 8. Date of B Month, D 02 1	irth Pay, Year) 5 58	Cour	lace (State or Foreign http://
	yland yow		10a. State 10b. County		10c. City, Town o	r Location					1	0d. Inside City Limits
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	with the Maryland a or 28a-f show	Director	10e. Street and Number			10f.	Zip Code			10g. Citizen of	What Cour	ntry?
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36	or its	by Funeral	11. Marital Status XXVeVer Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2☐ If Yes, Give Year or Dates:			cedent of Hoecify Cuba 2 XNo	ispanic Origin an, Mexican, P Specify:	? (Specify Yes or N uerto Rican, etc.)	o- 14. Ra Bli Speci	ace - Americ ack, White, ify:	
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yla	2 should be and Mental is marked craumatic every	10	Talmadge Gain						lis But			
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship						r Rural Route Numb			
	s 1 and 2 of Health item 27 other tra		Phyllis Butle 20a. Method of Disposition	r-Mother					t, Balt			21209
Baltimore,	e = 5		V⊆Burial 2 □Cremation 3 4 □Donation 5 □Other (Spec	Removal from State	20b. Place of Di cemetery,					20c. Location		
- E	permit. Pa Depertmen Important any injury		21. Signature of Funeral Service Lie		King M	emor:	and Addres	Park 7	/19/05	Randal.	lstow	n, Md
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.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic 5 □ Other (ate of deliver onth	y Day Year
٥,	es that igned b	by Pi	Part II. Other significant conditions	contributing to death be	ut not resulting in th	e underlying	cause give	n in Part I.	23e. Did 1	obacco use con	tribute to the	e cause of death?
rd	w require been sig should b	pa							_ 10	Yes 2□No	3 🗌 Proba	bly 4 Donknown
Vital Records,	law re as be 2 sh	Completed							24a. Was		Were autop	sy findings available
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Div	0	i Certification:	4 Homicide determined	building, etc	. (Specify)				City or To	wn, State)		
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	To t withi To tl	Σ	29b. Signature and title of certifier	ą.		2	9c. License		,	29d. Date signe		
)			A	LGRAIN			8	955	1	7/12	105	
	1		30. Name and address of person who Har Hain Ai	completed cause of de	math (Item 23a) (Type)	e Print)	anyk	and c	General	1 Hosp	sita	l_
	Sta Registr		31. Date filed (Month, Day, Year)		r's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 200 S 6:30 PM **Physician** July 0 Teresa Ann Simms /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Jaint Asno health Gre If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-4-1943 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Months Maryland 212-42-0357 1 □ M 2√2 F 62 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or iteme 23s or 28s-f show the Medical Exampler must be notified at N/A Baltimore 1 Ves 2 No MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 313 S. Furrow Street 21223 U.S.A. Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If text 27 Is marked other than "natural", or Iteme 23 ury or other traumatic event, the Medical Exprintment results. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho þ 3/2Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Deli Clerk Deli 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Heiland Anna May Goodrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 248 Greenfern Way Lansdowne MD 21227 Sandra Bayne/Daughter 20b. Place of Disposition (Name of cometery, crematory or other place Bayview Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition tment of 1 ☐ Burial 2 ☑ Cremation 3 ☐ RemovaLtrom State 7-14-2005 Baltimore, MD permit. Pag Department Important: I any injury o Ponation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 21. Sign ture of Funeral Service Kilcens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death netrotate hing Immediate Cause (Final disease or condition resulting in death) 5 months Physician /Medical Examiner Quecks. sendo moras Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 Z No been signed by the should be detached 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐Unknown 1 🗷 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 1 ☐ Yes 2 ☐ No this certificate rector. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) amach P17600 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar MITIKIRI, XIRUPAMA

31. Date filed (Month, Day, Year)

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9005 Coton Avenue

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			Registrar			U	enilicate of	Deain	1.55	Reg. Net)	5 23035
	Physici	an	Decedent's Name (First, Middle, La	st)					Month	Day Y	ear
	/Media		Carole S. St	ephan					<u> </u>	9, ^{Day} 2005 Y	1:48A. ^M
	Examir	ier	4a. Facility Name (If not institution, giv					or Location of Deat	h	4c. County of	
			Baltimore-Washin					Burnie		Anne A	
	Funeral		5. Social Security Number 6. S	Sex 7. I□M 21KTF	Age (In yrs.		Months Days		(Month, Da	th ly, Year) 9	. Birthplace (State or Foreign Country)
	Director		214-44-/14/	TO W. ZAN	60	Yrs.			Nov. 2	, 1944 1	Maine
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or	Location				10d. Inside City Limits
2	sho	ក	Maryland Anne Ar	unde1	S	everna	a Park				1 ☐ Yes 2% No
0	he M	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Country?
2	with Dean						211	1.6			States
arole	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show the Mailcel Examiter must be notified at	Funerai	6 Holliben Cour		et Everie II	6 42			anaity Vac as No		American Indian,
()	er de Item	un	11. Marital Status	12. Was Decede	es?	.5.	If Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puert	o Rican, etc.)	Black,	White, etc.
36	s aft	by F	1 ☐ Never Married ★★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2√3 If Yes, Give Year or Date			1 ☐ Yes 2√2 No	Specify:		Specify:	White
) (5-0036	hour tural	pe	15. Decedent's E			162 Dec	edent's Usual Occu	ination		16b. Kind of Busin	ness/Industry
C 75	n 72	iet	(Specify only highest gra	ade completed)		(Giv	e kind of work done DO NOT use retire	during most of wor ed)	rking	TOD. THING OF EDGIN	lood/industry
72	withi ene. than	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		nemaker			Own Hor	ne
20	filled Hygi ther		17. Father's Name (First, Middle, Last)		1 1101		18. Mother's Nar	ne (First, Middle	, Maiden Surname)	
0/1 and	d be antal	Be c	Thomas D. Smi	th				Jane 0	urand		
1012	d 2 should be filed within hand Mental Hygiene. 7 Ia marked other than "raumatic event, IL e Max	70	19a. Informant's Name/Relationship (19b. Ma	ling Address (Stree	at and Number or Ru	ıral Route Numb	er, City or Town, Sta	ate. Zip Code)
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 Ia marked other than "natural", or items 23a or 28a-1 show other traumatic event, if e.M. Jical Ex., infert. in ust be notified at		Charles P. Steph		and		Holliben		rna Parl		146
(O o	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any injury or other tra once.		20a. Method of Disposition		20b. F	Place of Disp	position (Name of		Date	20c. Location - Cit	y or Town, State
٠ ، و	Pages nent of H int: If Ite		1 Burial 2 Tremation 3		110	· ·	ematory`or other pla rematory	Jul	y 14,	Catonsv	ille MD
Saltimore,	it. P intme intani njunj		* 4 ☐ Donation 5 ☐ Other (Specification Signature) Funeral Service Lice		rie				005		rire, in
Ba	permit. Departr Importe any inju			aus			•	ess of Facility uddick Fu			
			23a. Part1. Enter the disease, or com	polica ons that caus	sed the deat	b Do not e	421 Crain	Hwy S.E	. Glen I	Burnie, M	21061 Approximate
			shock, or heart failure. List only	one cause on each	h line.	ii. Do not o	ntor the mode or dy	ing, such as saidle	or respiratory a		Interval Between Onset and Death
	Physician '		Immediate Cause (Final disease or condition resulting in death)	a/	Acut		yocardia	al Infar	tion - A	nterosepte	al I hour
	/Medical Examiner		1	Due to (or	as a conseq	uence of):	,				
1		<u>_</u>	Sequentially list conditions,	b. — Due to (or	as a conseq	ulacco oti).					
V	ed isit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 t0 (01	as a conseq	puerice or,					
	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	c	as a conseq	mence of):					
Box 68760,	cian cian buria					,					
87	death certificate b attending physic d for use as the b	dic		d							
9 ×	ding	/Me	IF FEMALE:	23c. If yes, outcor	me of pream	ancy				and Date	
Bo	ath c	lan	23b. Was decedent pregnant in the past 12 mooths?	1 Live birth	1 2 ☐ Feta	I death 3	□Ectopic pregnance	су		23d. Date o Month	Day Year
	the a	Physician/Medical	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant 9☐ Unknowr		leath 5	Other (specify) _				
Division of Vital Records, P.O.	v requires that the de been signed by the s should be detached		Part II. Other significant conditions of	contributing to deat	h but not res	ulting in the	underlying cause a	ven in Part I	23e. Did to	obacco use contribu	te to the cause of death?
Š,	res t signe	by				oung in the	angonymig acces g				Probably 4 Bunknown
orc	neen :	etec	Covalo	myspath	7						
ec	has b	ompieted							24a. Was autop	sv prio	e autopsy findings available to completion of cause of
=	sician: The l certificate ha rector, page	Con								med? dear	Yes 2□ No
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						ith (Check only o	ne)	
Ź	hysic his co	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa		ER/Outpati	BILL SLI DOA			dence 6 Other (Specify)
ט	ding Physi h. After this c funeral dir		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of li (Month,	njury Day Year)	28b. Time Injury	Wo		28d. Describe I	now injury occurred	
9.	ittendi death. ctor: A / the fu	ati	2 Accident investigation	_				Yes 2 No			
Ξ	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place of	Injury - At he etc. (Specif	ome, farm, s (y)	treet, factory, office		28f. Location (3 City or Tox	Street and Number o vn. State)	or Rural Route Number,
Q	ital c rs af ral D led ir	Ce									
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but	cai	(Check only 2 Medicel Exer							cause(s) and manne date and place, and	er as stated. due to the cause(s)
	the hin 24	Medical	one)	and manner	stated.						
	Neith Con	2	29b. Signature and title of certifier	0 5				se number		29d. Date signed (N	
				ohun m	7)		>	58000	>	Julyo	2005
	10		30. Name and address of person who	completed cause	death (Item	п 23а) (Туре	e, Print)				1,2005
March 1	lo		MARC OKUN	mD 1	417 1	MAD	29 MOZ.	TUK DUIN	E Gre	~ Bur	IE WD FLOPI
	Sta		31. Date filed (Month, Day, Year)	32. Regi	istrar's Signa	ature	1000				
	Regist		JUL 14	2005 32. Regi	due	Ji J	green_				
DH	MH 17 Rev 1/2	001									

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 4a. Facility Name (If not institution, give street and number) 2000 /Medical 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltmore Bryver Medical Conter Johns Horus If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year) Yrs 1973 new Jersug Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic avent, the Medical Examinar must be notified at 1 Yes 2 □ No NA by Funeral Director altimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Itams 23a or 1226 001 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Never Married 2 ☐ Married Black 5 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 Specify Specify: 3 ☐ Widowed 4 ☐ Divorced "netural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT up retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ont: If item 27 Is marked othar than ' Elementary/Secondary (0-12) College (1-4or 5+) Amtrack otter 12th NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Welch Howard (raylene ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundack, mb. 21224 Smith muther 6212 oppre way Gaylene other 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State č permit. Page Department of Importent: If any injury or once. -13-05 ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Ser Fred HILTON Pass 21229 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Due to (or as a consequence of): /Medical Examiner SECTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Preummi Multi loba Due to (or as a consequence of): Completed by Physician/Medical as the l use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy 5 Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No of Vital Records, P.O. detached 9□ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation Injury Division 1 Natural after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by 4 Homicide within 24 hours a
To the Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe AFZ664200-H34 a all who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 4940 MD N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUL 1 4 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item #8617 per fln 2845 7/19/10/1/19mate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** ARROLL ノフ 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Joseph 5. Social Security Number OSPICE Ichey 140RC 8. Date of Birtt 8-11-1932 9. Birthplace (State or Foreign Month, Day Year) 7. Age (In y/s. last birthday) 6. Sex **Funeral** 1 M 2 F Days Months Hours 212-30-7235 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28e-f show treumetic event, the Medical Examinar must be untified at 1 ☐ Yes 2 No BALTIMORE DUNDALK MARYAND 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 710 NDALK HUENYE 40+ B-2 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) RUCK DRIVER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be OVID H. SIMONS 2 should be t and Mental F ERNA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4D 21060 Health item 27 KOAD G/END ARGAMET Spayse 103 URNIE SIMMONS 6/EN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date Department of Fimportent: if ite 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State VALLEY MEMORAL JULY 16, 05 IIMONIUM ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service License 22. Name and Address of Facility JOSEPH N. ZANNINO JR. FUNERAL HOME 263 S. Conkling St. Balto. MD 2122 any. 23a. Part1. Enter the disease, or comprilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

243 S. Conkling St. Balto. MD 21224

Approximate shock, or heart failure. Ust gony one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** cancer w/ metastases Lung disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): the attending physician hed for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ COPD 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an CAD autopsy 2 No 1 ☐ Yes Hospitei or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) a Dother (Decity) 05 pice examiner' Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 2 🗌 No within 24 hours after death. To the Funerei Director: A 1 Yes investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D13006 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Read St., Balto Md 101 I 4 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July ATHERINE 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Rose Cale
If Under 1 Year If Under 24 Hrs. Center HOSPI KU/ Inmore 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 F Days 217-72-5444 MARYLAND Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f shov Examinar must be notified at 1 ☐ Yes 2 No Baltimore Directo MARYAND

10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 CDAR by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: White 3 ☐ Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other then "nature treumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Boys Restaurant Dough and Mental Hygiene. COOK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Schloer 6 AN 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Importent: If item 27 Is. any injury or other treur. tiddle OAK GROVE DRIVE ! KAREN GREENSTRECT Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GREENMOUNT Cr ^¹ 4 □ Donation 5 □ Other (Specify) 05 CHATORA 21. Signatura Survice Con 22. Name and Address of Hillity
JOSEPH N. ZANNINO J
263 5. Conkling Street JR. implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thy one cause on each line. 23a. Part1. Enter the disease, or coshock, or heart failure. Immediate Cause (Final Physician Kespiratory tallure disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Encephalopathy Sequentially list conditions, if any, loading to in rediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed iver Fail re Due to (or as a consequence of): nding physician a Division of Vital Records, P.O. Box 68760, liver disease Metastatic Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for L in the past 12 months? 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 □ Yes 2 □ No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s certificate Yes 2 4 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 🗌 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 Tes 2 No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7/12/2005 person who completed cause of death (Item 23a) (Type, Print)
oh Herchelroath 90001 Franklin Square Drive 200€ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

		1 - For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death	d Mental Hyg		23039			
Physic		Decedent's Name (First, Middle, La	Russell Lyall Smith		2. Date of Deat Month	Day Year y 12, 2005	3. Time of Death 4:15 p M			
/Medi Exami		4a. Facility Name (If not institution, giv	e street and number) Morningside House	4b. City, Town, or Location of D		4c. County of Deat	oward			
Funeral Director		5. Social Security Number 6. S 291.01.1433		If Under 1 Year If Under 24 I Months Days Hours N	Hrs. 8. Date of Birth (Month, Day,		hplace (State or Foreign nuntry)			
Maryland e-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Ho	10c. City, Town or Lo	licott Citu			10d. Inside City Limits			
with the 3e or 28e	i Direc	10e. Street and Number 5330 Dorsey Hall Drive	· Ant #313	10f. Zip Code 21042		0g. Citizen of What Co	ountry? S.A.			
ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f ehow or other treumatic event, the Modical Exaculter trivat be incliffed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pi 1 ☐ Yes 2 ☑ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White Specify:				
within 72 hor ene. than "natur	Completed	15. Decedent's E (Specify only highest grade) Elementary/Secondary (0-12)	ide completed) (Give	dent's Usual Occupation b kind of work done during most of DO NOT use retired)	working	16b. Kind of Business/ Industra	Industry til brushes			
ould be filed w Mental Hygier arked other th	To Be Cor	17. Father's Name (First, Middle, Last,	4	Industrial Engine	Name (First, Middle, I	Maiden Sumame)				
and 2 should alth and Men 27 is marke	-	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number of 223 Wine Spring Lane			Zip Code)			
permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tre once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Denation 5 ☐ Other (Specif	y) Bay	matory or other place)	Date 07/13/2005	20c. Location - City or Baltime	Town, State ore, MD			
Physician /Medical Examiner		Imm-date Cause (Final dis vise or condition resulting in death)	plications that caused the death. Do not en one cause on each line.	2. Name and Address of Facility Slack Funeral Ho 3871 Old Columb ter the mode of dying, such as car	oia Pike Ellicott diac or respiratory arro	City, MD 21043 est,	Approximate Interval Between Onset and Death			
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			23d Date of dol				
The law requires that the death certifical ate has been signed by the attending phage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal death 3 [□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	Day Year			
faw requires that as been signed b			contributing to death but not resulting in the ULATION; CHRONIC			pacco use contribute to es 2□No 3×Pr	the cause of death?			
The ta ate has page 2	Completed by	PULMONARY DIS	SEASE; STROKE		24a. Was a autops perform 1 ☐ Yes 2	y prior to	utopsy findings available completion of cause of 2 No			
To the Hospitel or Attending Physicien: 1 within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director, p	Certification; To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
Hospitel c 24 hours af Funerel D	edical Cer	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa-	nysician: To the best of my knowledge, dear miner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and p evestigation, in my opinion, death of	lace, and due to the co	ause(s) and manner as ate and place, and due	s stated. to the cause(s)			
/	Med	29b. Signature and title of certifier	7	29c. License number		9d. Date signed (Mont.	-			
1.5 Si	ate		completed cause of death (Item 23a) (Type 8186 Lark Brown Road Elkric 22. Registrar's Signature							

			For State	State of Marylan	-			Mental Hy	giene					
			Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death											
	Physici	an	C, C	Day Yea										
	/Media		4a. Facility Name (If not institution, give s	Pars		4b. City, Town, or	1		8 2000					
	Examir	er						un	4c. County of De					
	F		North Arundel Hos 5. Social Security Number 6. Sex		last birthday)	Glen Bur	nie If Under 24 Hr	s. 8. Date of Birtl	Anne Aru	nde1 lirthplace (State or Foreign				
	Funeral Director			M 2⊠F 49	Yrs.	Months Days	Hours Mir		, Year)	Country)				
			Usual Residence of Decedent					9-24-1	.955 MD					
	ylan how		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits				
	a-f s	ctol	MD Anne Arun	del Gle	n Burn	ie				1 ☐ Yes 2 No				
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?				
	23e	al	1403 Houghton Road	d		21061			U.S.A.					
	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f show he Medical Exeminer must be notified at	by Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		Was Decedent of His f Yes, specify Cubar	spanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Ar Black, WI	nerican Indian,				
36	s afte or h	γFι	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give	1	Yes 2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	1110, 010.				
21215-0036	hour turel	d b	3 Widowed 4 Noivorced	Year or Dates:	10: 5				White					
<u>.</u>	in 72 i "na	Completed	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occupa kind of work done d DO NOT use retired)	uring most of w	orking	16b. Kind of Busines	ss/Industry				
7	with ene. ther	mc	Elementary/Secondary (0-12)	College (1-4or 5+)		ities Ass			Nursing C	are				
	filed Hygi sther	Č	17. Father's Name (First, Middle, Last)		110010			ame (First, Middle,		are				
<u>a</u>	ld be ental ked cev	To B	Francis Clinton Ca	arter				leanor Ta						
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be nullised at once.	_	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street a			r, City or Town, State	Zip Code)				
	nd 2 lith a 27 is r trat		Ms. Jennifer Sears	- Daughter					MD 21061	, 1.0 0000)				
timore,	s 1 a f Hea item othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or cemetary, crematory or other place)											
Ë	Page ent o nt: If		1 (Burial 7 Cremation 3 Removal from State 2 Cometery, crematory or other place) 4 Donafton 5 (Specify) Meadowridge Memorial 7-14-2005 Elkridge, M											
<u>=</u>	artm orta		21. Signatul - uperal Servick License	98					Funeral H					
m	per imp any one) 10/ L Vele	Molizo	1									
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death	. Do not ente	or the mode of dying	, such as cardia	ic or respiratory arr	ie, MD 210 est,	Approximate				
	Physician :		Immediate Cause (Final	e cause on each line.		alsol 1	1			Interval Between Onset and Death				
	/Medical	1	distase or condition resulting in death)	Due to (or as a consequ		ed10/ /1	1148011	on		Immediate				
	Examiner				,									
	يجيد	ner	Sequentially list conditions, if any leading to immediate	Due to (or as a consequ	ence of):									
	cutec nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
Ö,	e exe ian a urial-	Ex	resulting in death) Last	Due to (or as a consequ	ience of);									
68760,	rificate be executed ng physician and as the burial-transit	edical	d											
_			IF FEMALE:	-										
Вох	eath certifi attending for use as	Physician/M	23b. Was decedent pregnant 23	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date of d	elivery Day Year				
	the a	/sic	in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of de 9 Unknown	eath 5	Other (specify)			Mortu	Day real				
2	res that the de signed by the a I be detached i	Ph	Part II. Other significant conditions con	tributing to death but not recu	iting in the us	darhina anuas anua	n in Dart I	22a Did tal	nace use sentificate	to the cause of death?				
Records,	The law requires that the death certifice has been signed by the attending vage 2 should be detached for use a	l by	Dicholes Mol	The	itting iir tri o ur	derlying cause give	nın Fantı.	1 X Ye		Probably 4 Unknown				
0	w require been sign	etec	Diguers Till	10173										
ec Sec	e 2 s	Completed	Myselvension					24a. Was a autops	y prior to	autopsy findings available occupies of				
<u></u>		Cor	/,					perform	ned? death?	s 2 No				
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	amitali të				ath (Check only on	θ)					
0	Physical this caral direction	P 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)												
L C	ding f h. After funer	lon	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work?		28d. Describe ho	w injury occurred					
<u>2</u>	Attendl death. ctor: A y the fu	Icat	2 Accident investigation 3 Suicide 6 Could not be	00- 01		100	es 2 □No	Last to the						
Division	or A after of Direction by	ertification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, tarm, stre	et, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,				
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	0	29a. Certifier 12 Certifying Physi	ician. To the heat of multi-	uladaa daad									
	24 hos Prun etely	edical	(Check only one) Medical Examin	ician: To the best of my knov er: On the basis of examinati and manner stated.	ion and/or inv	estigation, in my opi	nion, death occ	e, and due to the ca urred at the time, da	iuse(s) and manner a ate and place, and du	s stated. e to the cause(s)				
	oth ompl	Me	29b. Signature and title of certifier	1		29c. License	number	2:	9d. Date signed (Mor	th, Day, Year)				
	->		> Ank	Kaplan		Dar			7.0	2005				
	. 1		30. Name and address of person who cor	inpleted cause of death (Item	23a) (Tvne 5	D250	011		100	KUUJ				
	4		Isa E Kanla	n MD 784:	5 Mak	ward	Rd # 3	(Clout	Bulmin N	12 21000				
	* Sta		31. Date filed (Month Day, Year) 4 20	32. Rigistrar's Signati	ure	2 40		- ullie	1110	J 5 5 6				
	Reaistr	ar	UUL 1 4 (U	U. 1 / 100	PT AL	A ANTA								

			State of Maryland / Department State of Maryland / Department Co.	artment of Health and N			
			Registrar 1. Decedent's Name (First, Middle, Last)	Timcale of Dealif	2. Date of Death	g. No.2005	3. Time of Death
	Physici		Erma K Shaw		Month TUNE	Day Year	2:48AM
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Doctors Community Hospital	Lanham		Prince Ge	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 82 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Mar 27,	Year) 9. Birthp Cour 1923 Nort	place (State or Foreign ntry) h Carolina
	ס		Usual Residence of Decedent		11a1 2/9	1925 NOIL	ii carorina
	arylar show	-	10a. State 10b. County 10c. City, Town or Lo			1	Od. Inside City Limits
	the M	Director	MD Prince George's Glenard	en 10f. Zip Code	100	g. Citizen of What Cour	1 Yes 2 No
	3a or	i Dir	1524 5th Street	20706	100	USA	ury :
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
36	or flo	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☐ No Specify:	1110411, 810-)	Black, White,	
Ş	turel'	ed b	15. Decedent's Education 16a. Decedent	dent's Usual Occupation	16	B. Kind of Business/Inc	lack
212	hin 72 e. an "ne Me.ili	Completed	(Specify only highest grade completed) (Give life. (Gi	kind of work done during most of work DO NOT use retired)	ing	DD. INFIG OF DUSTINGS WITH	dustry
2	ed wit ygiene yer tha	Con	10 He	omemaker		Own Home	
and	ntal H ed oth ed oth	Be	17. Father's Name (First, Middle, Last) Johnnie H. Kimber	18. Mother's Nami Sarah I	e (First, Middle, Ma Frances	aiden Sumame)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Heatth and Mental Hygiene. Item 27 is marked other than "naturel" or items 23a or 28a-f show ther traumetic event, the Medical Eval. I are must be I calified at	^L	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailir	ng Address (Street and Number or Run		City or Town. State. Zin	(Code)
	d 2 th a trai			4 5th Street Glena			
Baltimore,	ges 1 an t of Heal If item 3 or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition Sweet and Company Countries and Co	sition (Name of Interpretation	Date 20	Oc. Location - City or To	own, State
Ě	Pages tment of I tent: If it		'4 □Donation 5 □Other (Specify) Bapt. Chu	urch Cem. $7/3/6$	05	Yancyville	, NC
g	permit. Pages Department of Importent: If it eny injury or c		Mc i linda and Mc	2. Name and Address of Facility CLaurin Funeral Ho	ome		
			28a. Part1. Enter the disease, or complications that caused the death. Do not ent	.O. Box 456 Reids er the mode of dying, such as cardiac	or respiratory arres	C 27323-04	Approximate
	Physician		Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Put to a 1	ti (Interval Between Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or as a consequence of):	1			
	Lxammer	.	if any, leading to immediate Due to (or as a consequence of):	Mythree			
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ox e	eath certific attending p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			20 1 Date (1 E	
ñ	the death certific y the attending p	Physician/Me	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delive Month	Day Year
J.	at the de by the	hys	9 □ Unknown				
_	The law requires that te has been signed boage 2 should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		cco use contribute to th	
ecords,	w require been si should t	eted	Ceres 10 vascular 11 occo			2 No 3 Prob	
Z Z	The law cate has I page 2 s	Completed			24a. Was an autopsy performe	prior to con	osy findings available apletion of cause of
VIta		O	25. Was case referred to medical	26 Place of Death	1 Yes 2	ZNo 1 □ Yes	2 No
	nysici nis cer I direc	To B	examiner? 1 Yes 2 No Hospital: 1 npatient 2 ER/Outpatien	Other		ce 6 Other (Specify	·)
n of	ding Ph h, After thi funeral		27. Manper of Death 1 Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	28d. Describe how	injury occurred	
DIVISION	of or Attendi after death, Director: A d in by the fu	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, structure 25 could be determined.	M 1 Yes 2 No	28f Location (Stree	et and Number or Rura	I Route Number
2	spitat or At ours after onered birect filled in by	Certification;	4 Homicide determined building, etc. (Specify)	oot, ractory, office	City or Town, S	State)	Triodio Trainibor,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director, completely filled in by the funeral director,		29a. Certifier (Check only (Ch	n occurred at the time, date and place,	and due to the caus	se(s) and manner as sta	ated.
	To the Hos within 24 h To the Fun completely	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		. Date signed (Month, L	
	5 × × 5		How AR Aged MO	0000598	93 0	6 27	05
	/		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		0/ //	
	5		AMIRALI AMJADI 575 MAINSTA	CEET SUITE DE	3 LAUR	LEL, UD o	10207
	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	and a			
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		1 - For State Registrar	e of Marylar		ertificate			na mentai		ne N200	=	2301.2
		Decedent's Name (First, Middle, Last)		11 -	1111041				of Death;	. 1	J	3. Time of Death 🛆
Physic /Medi		BEITY LEE	IA	111	. 7			Mont	7-/	OZ/O	eer 5	12.15 MI
Exami		4a. Fecility Name (If not institution, give street at			4b. City,	Town, or	Location of	Death	'/	4c. County of	Deeth	
Europel		Heritage Harbor Nursi	ng Home 7. Age (In yrs.	last birthday) If Under		polis	4 Hrs. 8 Dete	of Birth	Anne A		
Funeral Director		404-22 - 2084 1□ M 25	3-E	33 Yrs.	Months	Days	Hours	Min. (Mon.	th, Dey, Yo	,1922		ce (Stete or Foreign y) ucky
and w		Usuel Residence of Decedent 10a. State 10b. County		ty, Town or L	ocation					1-2		d. Inside City Limits
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death with the Maryland ms 23s or 28s-f ehow must be notified at	Director	10e. Street and Number			10f. Zip	Code			10g.	Citizen of Wha	at Countr	y?
ath wi	la l	2700 South Haven Road				403				nited S	State	s
ter de	Funeral	_ Arm	Decedent Ever in U ed Forces?	I.S. 13	Was Deced If Yes, spec	ent of His rfy Cubar	spanic Origi n, Mexican,	n? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Bleck,	American White, et	
Urs at urs at all, or	by	If Ye	Yes 2 ∏ M o es, Give ror Date <i>s</i> :		1 ☐ Yes 2	2□ x No	Specify:			Specify:	Whit	e
d 21215-0036 filed within 72 hours atter Hygiene other than "natural", or lite than "that Medical Examina	Completed	15. Decedent's Education (Specify only highest grade compl	eted)	(Giv	edent's Usua e kind of wor	k done di	urina most o	of working	168	. Kind of Busin	ness/Indu	stry
Within Within then	dm		ege (1-4or 5+)	life.	DO NOT us	e retired)) -		_		ъ	
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arylan should be nd Mental marked o	To B	Frank Berry Blackb	ırn				S	elena Hi	irsi1	la Brel	sfor	d
Maryland Id 2 should be file Ith and Mental Hy ITY Is marked oth traumatic event		19a. Informant's Name/Relationship (Type, Prin Barry Talley, Son	1)					or Rural Route N				ode)
		20a. Method of Disposition	20b. F	Place of Disp			rive,	Edgewat		MD ZIU3 Location - Cit		- State
Baltimore, permit. Pages 1 ar Department of Hea mportant: If Item: any injury or other ance.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State	edar H	matory or ot	her place				inceton		
Balti permit. I Departm Importar any injur		21. Signiff e of Funeral Service Livensee		2	2. Name and					neral H		псиску
a 83 5 5 8	1	July 1 1	MO11					n Street			, KY	42445
		23a. Pert1. Enter the disease, or complications shock, or heart failure. List only one cause	on each line.		Iter the mode	of dying	, such as ca	ardiac or respirat	ory arrest,		- Ir	pproximate hterval Between Inset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):										moot and Dough
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687 tificate ig phys		d	/ / / -		/	- ///	01//					
vision of Vital Records, P.O. Box 6870 Attending Physician: The law requires that the death certificate to death. Sector: After this certificate has been signed by the attending physic the tuneral director, page 2 should be detached for use as the to	Physician/Med	230. Was decedent program	s, outcome of pregna ive birth 2 Peta	ancy Il death 3	□Ectopic pre	onancy				23d. Date o	,	
O. E. the dear of the deficient for	ysici	1 Yes 2 No	Pregnant at time of du Unknown		Other (spe				-	Month	Da	ay Year
, P.O. that the de ned by the a	by Ph	Part II. Other significant conditions contributing	to death but not res	ulting in the	underlying ca	use givei	n in Part I.	230.	Did tobac	o use contribu	ite to the	cause of death?
Records, P he law requires that he has been signed to	ed b	Avenua						_	1 🗌 Yes	2 No 3	Probab	iy 4 Monknown
eco lawre as be	Completed	HTN						24a.	Was an autopsy	24b. Wer	e autops	y findings available letion of cause of
al R								101	beutormed	2 dea	th?	No
Vital sician: T certificate irector, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 Inpatient 2	FB/0		Other		Death (Check of				
g Phy g Phy er this	n: To	27. May er of reath 28a.	Date of Injury (Month, Day Yeer)	28b. Time of		lc. Injury	at	ing Home 5 28d. Desc		injury occurred	Specify)	
Sior endin eath. or: Att	atlo	2 Accident investigation	Month, Day 1961)	Injury	М	Work1 1 □ Y	r es 2 □ No					
Division of or attending Phy after death. Director: After this in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e.	Place of Injury - At his building, etc. (Specif	ome, farm, si y)	reet, factory,	office		28f. Locat City o	ion (Street or Town, St	t and Number o tate)	or Rural R	loute Number,
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:		29a. Certifier 1 Certifying Physician: 1	o the best of my kno	wledge, dea	th occurred a	t the time	a date and r	place, and due to	the cause	a(s) and manne	ar as state	ard.
he Ho in 24 h he Fu pietely	Medical	CHeck only 2 Medical Examiner: On	the basis of examina manner stated.	tion and/or in	vestigation,	in my opi	inion, death	occurred at the t	ime, date	and place, and	due to th	e cause(s)
To the within 2. To the I complet	Σ	29b. Signature and title of certifier	- AA A		29c.	License	number	92	29d.	Date signed (A	Aonth, De	y, Year)
4	Les	30) Name and address of person who completed) / / / D	230\ /7	D (10 2	004	080.		7/2	10.	ン・
3		KICHALD AKOTO M.D	. 344 W	· UNI	1.132	UP,S	41 TE	-326,5	5/60	SPR,	MO	20901.
	ate	31. Date filed (Month, Day, Year) JUL 1 4 2005	32 negistrar's Signa			,					•	1
Regist DHMH 17 Rev 1/2		2001 4 2000	Elem 1	The Age	all		-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No 1 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** TUCKER 05:02 AM a Th JERRY JULY 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death Sinai hospital Baltimore n/a If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours ★ M 2 F Yrs **Director** 215-44-7603 58 June 18, 1947 Washington DC Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene. importent: If item 27 is marked other then "naturel", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examplest intest by notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits rthen "naturel", or items 23s or 28e-f show the Medical Exemperatural be notified at ¥HYes 2 □ No MD Anne Arundel Glen Burnie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 423 Wellham Ave. 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes XX No Specify: white 3 ☐ Widowed 4 ♣ Divorced Specify: white δ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Construction worker Private Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Heber Bennton Tucker Sr. Mary E. Tredway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laura Ann Tucker- daughter 1 Bethway Dr. Sykesville, Maryland 21784 20b. Place of Disposition (Name of commetey, crematory of other place)
Baltimore Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State July 13, 05 Baltimore City '4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore Maryland 21229 23a. P if 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a ch line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): ARTERY disease or condition resulting in death) DISEASE IYEAR /Medical **Examiner** ZYEAR CIRRHOSIS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use es the burial-transit Due to (or as a consequence of): nding physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant been signed by the etten should be detached for u 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificete 1 Yes 2 No 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA s efter deam.
/el Director: After this c Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 T Homicide To the Hospital o within 24 hours eff To the Funerel DI 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D curry M. 10054739 JULY 9 m

3

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

W. 32 Registrar's Signature 31. Date filed (Month, Day, Year) JUL 1 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Belvedere

Donna

2434

Avenue

Baltimore,

2005

Maryland

amend item/9, perfn, G45, 7/14/05 VI Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 8 per FH, C848, 10/26/05dhb
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** EMMA Ja 11:00 A.M /Medical 4a. Facility Name (If not institution, give street and number)

1810 9 - FEDERUL SH 4c. County of Death 4b. City, Town, or Location of Death Examiner BAHIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) -97 96 Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F N.C Director 217-540800 12/19/1908 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 No Completed by Funeral Director BALTIMURE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/2/3 U.5.A or Items 23a 1810 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "netural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Wyatt connudny SIMERA BRANder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1810 8. FEDERAL St BATHMERE, MD 21213 148888 Thumas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or ARbutus Memorial Parte BAHIMIRE MD * 4 ☐ Donation 5 ☐ Other (Specify) July 14,2005 21. Signature y Funeral Service Licenses 22. Name and Address of Facility 88 Hs Funeral Hume Latricia Best 1129 N. CAROLINE SI BAHIMORE MARGICIAN 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RECURPENT YEARS CARCINOMA OF /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to antibulate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by NIDAM 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28987 30. Name and address of Son who completed cause of death (Item 23a) (Type, Print) BALTO, MP CARL SPERLING BLVD 5601 32. Register's Signature 31. Date filed (Month, Day, Year) 1 4 2005 BLALIA Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 24a State of Maryland Aperatment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical Month AUGHN 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CTal 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. -36-7886 Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow Examiner must be notified at 1 Yes 2 □ No Director MARYLAND 10e. Street and Number Citizen of What Country? ANETTE COAD 00 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced "naturel", or other treumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygiei 7 Is marked other th Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 VIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a 004 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation permit. Page Department of Importent: If any injury or ZION CEMETERY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DOX10 ninutes /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ROVED BY Due to (or as a consequence of): Ó. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 DHnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? After this certificate 1 ☐ Yes 2 ☐ No 2**X** No or Attending Physicien: To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner?

1 ☑ Yes 2 ☐ No Medical Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 No death. Unknown™ 2 Accident 6 ☐ Could not be 3 DSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number) determined 4 Homicide 5601 Loch Raven Blvd., Balto., M Hospital within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 LOCH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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	_			- State Registrar				Ce	rtificate of	Death				105	23046
		Physicia	_	1. Decedent's Name William		ısı) lett Jr	•					2. Date of De Month	Day	Year 05	3. Time of Death
		/Medic Examin		4a. Facility Name (II	f not institution, giv	re street and num	ber)		4b. City, Town,	or Location of	of Death			unty of Death)
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		Funeral Director		5. Social Security N 217-40-78	umb e r 6.5	M 2 F	7. Age (In yrs. I 63	last birthday) Yrs.	Months Days		Min.	8. Date of Bir (Month, Da Dec. 21	th ly, Year) - 1941	9. Birth Cou Md	nplace (State or Foreign untry)
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		with the Maryland a or 28a-f show	ō	10a. State Md.	10b. County Baltin	ore	10c. City	r, Town or Lo Dunda							10d. Inside City Limits 1 ☐ Yes 2 No
		the N 28a-1	Funeral Director	10e. Street and Nur	mber				10f. Zip Code				10g. Citizen	of What Cou	untry?
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~		er nu	iner	11. Marital Status		12. Was Dece	dent Ever in U.	S. 13.	Was Decedent of If Yes, specify Cult	Hispanic Ori	igin? (Spe	city Yes or No Rican, etc.))- 14.	Race - Amer Black, White	
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11017	Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hean * natural; or Nems 23a or 28a-f show morprotant: If them 27 is marked other then * natural; or New Jean Exertite to ust be notified at any injury or other treumatic event, it is Mode.		19a. Informant's Na Carolee	willett	(Type, Print) Wif	ē.	19b. Maili 340	ng Address <i>(Stree</i> 1 North	t and Numbe Point	er or Rura Rd.	Route Numb Balto.	er, City or To Md. 2	wn, State, Z 1222	ip Code)
1.1	Baltimore,	ges 1 ar t of Hea If item 3 or other	Î		Cremation 3 (emetery, cre	osition (Name of matory or other pla Cremato	ice) J	uly			ion - City or I	Fown, State
~	altim	mit. Pa bartmen bortant: / injury 29.		*4 □ Donation 21. Signature of Fu	5 Other (Speci meral Service Lice			_	2. Name and Addr		200 ≱1 но		Balti Dundal		
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	ai H	(0 -		window	costic	Acido	610 6	espir	atory R	adure		1 Tes	2/1/10	1 Yes	2 No
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	sior	Attendin death. ctor: Aff y the fur	atio	1 Matural 2 Accident	5 Pending investigation	on				Yes 2					
	Division of Vital Records,	or Att	Certification:	3 Suicide 4 Homicide	6 Could not determine	289. Place	of Injury - At he ng, etc. (Specif	ome, farm, st	reet, factory, office	•	1		'Street and N wn, State)	umber or Ru	ral Route Number,
	_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical Co	29a. Certifier (Check only one)			isis of examina		th occurred at the ovestigation, in my						
		To the within To the comple	Med	29b. Signature and	title of certifier	1		na N		nse number					n, Day, Year)
		~		30. Name and add	ress of person who	complete daus	e of death (Item	n 23a) (Type		6331				12.05	
		8		Dr. Jos	ephine	Owus	u-Sa	hyi "	9000 Fran	Klin	Sque	cre Dr	ive Ba	ltimor	e, Md 21237
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner NESIS SPACREEK CENTER WNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs Months Days Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** 1 M 2□ F 109.38.1840 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show notified at 1 Yes 2 No Director the 10e, Street and Number 10g. Citizen of What Country? ma 23a or WITED STATES NLANE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? The Medical Examiner filed within 72 hours after ☐Yes 2 No 1 Never Married 2 Married Specify: WhITE Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Ā If Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry rthen Elementary/Secondary (0-12) College (1-4or 5+) PERFORMER 12 event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be file tment of Health and Mental Hy tant: if item 27 is marked oth jury or other traumatic event Be ARAQ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 3896 GREENMEATOW. BEATRICE ZAFFARONI, Date 20c. ocation - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: if it eny injury or o once. 1 Burial 2 Cremation 3 Removal from State BANIEW CREMATORY BALTIMORE, MD 4 Donaties 5 Other (Specify) permit. 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part1. Enter the disease or complications that caus shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest line. Approximate Interval Between Onset and Death Cancer Immediate Cause (Final disease or condition UNO **Physician** 7_ MOS resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Find the drying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) burial-1 P.O. Box 68760 attending physician Physiclan/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Year 5 Other (specify) ached I□Yes 2□No the 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 2 No 3 Probably 4 □Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 2□ No 1 Tes 2 XN0 1 Tes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) ှင 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending investigation within 24 hours after use...
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature)and Mie of certifier 29c. License number 29d, Date signed (Month, Day, Year) 9838 Genesi5 Creek and address of person who completed cause of death (Item 23a) (Type, Print) Center

State Registrar

DHMH 17 Rev 1/2001

JUL 1 4 2005

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ANNapolis

			For State Registrar	State of	Maryland / Dep	artment ertificate			d Mental H	lygiene Reg. No	000-	2301.0		
	Physici	an	1. Decedent's Name (First, Middle), Last) 7 / 1	INSKI				2. Date of Month	104	y Yeer	5. Time of Death		
	/Media	al	4a. Facility Name (If not institution			4b. City. To	own. or Lo	cation of D	eath J W	4	County of Dea	10.15A.M		
	Examir	er	Northwest Hosp		23.7		lalls				Baltimor			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthda	/) If Under 1 Months		Under 24 Hours	Hrs. 8. Date of (Month,	Birth Day, Year 2, 19	9. Bir	thplace (State or Foreign		
	Director		579-18-0187 Usuet Residence of Decedent	1□M 2\ F	85 Yrs.				JAN 1	2, 19	20 Sco	tländ		
	yland Now		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits		
	a-f sh	ctor	MD Anne	Arundel	Hanover							1 ☐ Yes 2 ▼ No		
	ith the	Dire	10e. Street and Number			10f. Zip C				10g. Ci	tizen of What Co	ountry?		
	s 23e	eral	7144 Ohio Ave		dent Ever in U.S. 13		.076	nic Origin	? (Specify Yes or	No-	USA 14. Race - Ame	erican Indian		
(0	r item	Funeral Director	11. Marital Status1 ☐ Never Married 2 ☐ Marr	Armed For	2. 7 No				? (Specify Yes or uerto Rican, etc.)		Black, Whit	te, etc.		
5-0036	72 hours after death with the Maryland natural', or liems 23a or 28a-1 show lisal Examinat must be natified at	क्	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Da	9	1 ☐ Yes 2½	No S	Specify:			Specify: wh	ite		
5-0	"natu	Completed	15. Decedent (Specify only highes	t's Education of grade completed)	16a. Dec	edent's Usual re kind of work DO NOT use	Occupatio	n n <i>g m</i> ost of	working	16b. F	(ind of Business	/Industry		
2121	within iene. than "	omp	Elementary/Secondary (0-12)	College (1-	4or 5+)	ne Work				Ca	lvert D	istillery		
þ	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. itiem 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exerticer must be notified at	BeC	17. Father's Name (First, Middle,	Last)				. Mother's	Name (First, Mid					
ylar	should be ind Mental Ind marked o	ToE	Andrew McGrow	1					bella Le					
Maryland	12 sho		19a. Informant's Name/Relations						r Rural Route Nu					
	1 and Health tem 27		Boni Sparrow - 20a. Method of Disposition	daugnter	20b. Place of Dis	position (Name	of	11, 0	wings Mi Date		MD 211 ocation - City or			
o E	90=5		Murial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S.		iate I	ematory or oth dge Men		rk 7	/13/2005	Elk	ridge,	MD		
Baltimore,	permit. Pages 1 a Department of Hea Important: If item any injury or othe		Meadowridge Mem. Park 7/13/2005 Elkridge, MI 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowrid 7250 Washington Blvd., Elkridge, MD											
			23a. Part1. Enter the disease or shock, or heart failure. List	complications that ca	used the death. Do not e	nter the mode	of dying, s	uch as car	diac or respirator	y arrest,		Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	- a. ADVA	VCGD CHIPOR	MC LUM	KADI	SEAS	E EM	PHYSO	EMA	YY		
	/Medical Examiner		rooming in odam,	Due to (d	or as a consequence of):									
-	1	Jer	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Dua to (.	or as a sonsaquense of).									
V	executed n and ial-transit	Examiner	that initiated events	c										
8760,			resulting in death) Last	Due to (d	or as a consequence of):									
687	certificate be nding physicia use as the bur	edical		d										
Box (eath certific attending pl for use as t	N/W	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy	Ectopic preg	naacu				23d. Date of de			
-	0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of death 5	Other (spec				-	Month	Day Year		
P.0	t th		Part II. Other significant condition	ons contributing to de	ath but not resulting in the	underlying cau	se given i	n Part I.	23e. D	id tobacco	use contribute to	o the cause of death?		
Vital Records,	Se US	Completed by	Coronamante	un discone	, chronie	nena	Ld	ingon	e · 1	Ses 2	□No 3□P	robably 4 Unknown		
O		plete	Cardionelina	they, &	SEASIS.				24a. V	fas an utopsy	24b. Were a	utopsy findings available completion of cause of		
R	The isate ha	Com	1.0							erformed?	death?	2 No		
/ita	ysician: The law is certificate has t director, page 2 s	Be	25. Was case referred to medical examiner?					3. Place of	Death (Check or	ily one)				
J.	Physician: this certific ral director,	. To	1 ☐ Yes 2 ☐ ₩6 27. Manner of Death	Hospital: 1 1 1 1 28a. Date o	ipatient 2 ER/Outpati		Other:	4 🗌 Nursir	ng Home 5 ☐ R		6 □Other (Spe	ecify)		
O	th. : After tunes	tion	1 Natural 5 Pendin 2 Accident investig	g (Mont)	n, Day Year) Intury	М	Work?	2 □ No	400. 200.	50 71017 11170	.,			
Division of	al or Attending F s after death. I Director: After Id in by the funera	Certification;	3 ☐ Suicide 6 ☐ Could determ	inod 289. Place	of Injury - At home, farm, ag, etc. (Specify)	street, factory,	office			n (Street a		ural Route Number,		
Ö	ital or rs afte ral Dir led in	Ceri		- John Strick										
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	ledical	(Check only 2 Medical one)	Exeminer: On the ba and mann	best of my knowledge, de sis of examination and/or er stated.	ath occurred at investigation, in	the time, n my opini	date and p on, death o	lace, and due to occurred at the tire	the cause(s	d place, and due	s stated. e to the cause(s)		
	To T	Σ	29b. Signature and title of certifie	enope	MD	29c.	D < /	umber		29d. Da	te signed (Mont	th 2005		
			20 1	o v	of death (Itom 32-) (T-	o Priet\	y 94	200		7	0			
	Sta	10	30 Name and address of person (COMO SW OW) 31. Date filed (Month, Day, Year)	I Range	a of death (Item 23a) (Typ	Youth	est 1	Yedia	of cente	, Kar	ndalls	to the cause(s) th, Day, Year) th) 2005 town, MD33		
	Regist		1111		George H	book	,							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) **Physician** 6 race /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury at Wicomico Hospice the Lake oastal If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-02-1929 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 ☐ M 2 ☐ F Yrs. 75 NOKESVÍLLE, VA **Director** 218-24-1080 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in then "naturel", or items 23e or 28e-f show the Medical Examinar must be notified at 1 ☐¥es 2 ☐ No Director WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 TROOPERS WAY 21804 death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Importent: If item 27 is marked other then "naturel", or iter any injury or other freumatic event, the Mudical Examinance. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US. GOVERNMENT 12 SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TESSIE FLORENCE MUNDY JACOB FRANKLIN SHUMAKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1902 E. CLEAR LAKE DRIVE, SALISBURY, MARYLAND 21804 NANCY WHITELOCK - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State NTL.MEM.PARK CEMETERY 07-06-2005 FALLS CHURCH, VA. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonature of Funeral Service Licenses 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA **Physician** /Medical Due to (or as a consequence of) STROKE - CETTERPOUTS CULHR
s a consequence of):

HECT DENT Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 233 Data of Sollware 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 **X**No Hospitel or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1/X Natural 2 ☐ Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical pletely (Check only one) and manner stated within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20/05 auce GRACO COASTAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES ISHIES 31. Date filed (Month, Day, Year) State JUN 3 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** June 7:05 p Michael Terry Avent /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 10 St. Andrews Road Anne Arundel Severna Park If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Y Oct. 30, 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex ^{Year)} 1944 **Funeral** 1**⊠**M 2□F Yrs. OK 545-64-2966 60 Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f shoy other traumatic avent, the Wedical Examiner must be notified at Severna Park 1 ☐ Yes 2 X No Anne Arundel MD Director the 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 5 USA 21146 10 St. Andrews Road Ітапя 23а Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Brack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1⊠Yes 2□No IfYes,Give Year or Dates: Vietnam 1 ☐ Never Married 2 Married White 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Citi Financial Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Juanita Gwendolyn Mayo Richard Leon Avent ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 St. Andrews Road, Severna Park, MD 21146 Nancy Jane Avent/Wife item 27 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition June 30, 2005 o = MD Veterans Cemetery 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD ö permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Parranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signalur of Juneral Service Licenses 10ml 62 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. anow Co Pnysician a 51 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) physician a Box 68760. IF FEMALE: esu. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s autopsy 1□ Yes certificate 2 X No To tha Hospital or Attanding Physician: Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 9 1 Tes 2 No this 28c. fnjury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death After t Certification: (Month, Day Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To tha Funaral Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 3 🗌 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe

State Registrar and address of

ompleted cause of death (Item 23a) (Type, Print)

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amend item//19a-b, per Inf. (845), //22/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24, 2005 Month **Physician** ROBBY 11:20A M L. ANDERSON /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bel Pre Rehabilitation Cen. Silver Spring Montgomery

9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Feb. 2, 1946 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **∑**M 2 ☐ F 59 577-58-9103 Director Texas Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after deeth with the Marylai nent of Heatth and Mental Hygiene.
snt: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show yor other traumaftc event, Ite Mayoral Experiment must be notified at any or other traumaftc. MD 1 ☐Xes 2 ☐ No Montgomery Director Silver Spring 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 11511 LoveJoy St 20902 Funeral U.S.A 12. Was Decedent Ever in U.S.
Armed Forces?
1 DX es 2 No 1965 If Yes, Give
Year or Dates: 1967 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: À Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Dept. Of Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12th Interior 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Spauling Ruffins Geraldine Reed 19aTlestante Narae/Eplationship (Danstitle) 192316 KAddes Vil 1943 and Symbol of Bural Floury Jun 2018 by or Town, State, Zip Code) 11511 LoveJoy Geraldine Ford St Silver Spring, MD 20902 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Md Veterans Cem 7/1/2005 Cheltenham, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signature of Funeral Serve e Licensee 246 N. Washington St Rockville, Md 20850 rock 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIAC ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ADVANCED COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit the death certificate be executed HEART FAILURE that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown AFIB, DM2, Renal insuffiency Completed Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 XNo this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending Injury 1 Natural death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 CCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 2

Registrar DHMH 17 Rev 1/2001

State

Box 68760

P.O.

Division of Vital Records,

32 Registrar's Signature

Judith Mbaoua 7513 New Hampshire Ave Takoma Park, Md 20912

easles 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) JUN 2 9

27

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** <u>8:4</u>5 ^{а м} Augustine Joseph Anastasi, Sr. June 26, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5110 Flanders Avenue Kensington Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🛣 M 2 🗆 F 579-40-4942 73 29, 1931 Washington, Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show y or other traumatic event, the Medical Exerciter must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō 5110 Flanders Avenue 20895 USA Items 23a Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 四Yes 2 No 1954-14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married SpecifyWhite Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 1956 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 Police Detective Municipal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosario Anastasi Angelina DeLeo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite V. Anastasi/ Wife 5110 Flanders Avenue, Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 29, June 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Fort Lincoln Cemetery * 4 □ Donation 5 □ Other (Specify) 2005 Brentwood, Maryland 21. Signature of Funeral Service Licent 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Er shock, of er the heart inal Immediate Ca **Physician** disease or condition resulting in death) Pancreatic Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-trar and resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physiclan/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year be detached for 4☐Pregnant at time of death 5 Cher (specify) o 9 Unknown 9 Unknown á ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2∏ No 1 ☐ Yes 2K No 1 TYes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home F Residence 6 Other (Specify) 2 1 ☐ Yes 2🏋 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident the 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of cont 29c. License number DC19655 June 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lombardy Cancer Center M.D. 3800 Reservoir Road, Podium B, Washington, DC 20007 John Marshall, 31. Date filed (Month, Day, Year) Registrar's Signature State 29 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year Andrea Ellen ALPERT 2:12 P M June 26, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 19749 Crystal Rock Drive #11 Germantown Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Pay, Jan . 1, Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 217-46-9861 1□M 2√∑F 54 Director Washington, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28e-f show the Medical Examiner must be natified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19749 Crystal Rock Drive #11 20874 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Be Completed by Specify: 3 ☐ Widowed 4 🖔 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) rmit. Pages 1 and 2 should be filed wil spartment of Health and Mental Hygien. portant: If item 27 is marked othar th y injury acothar traumatic evant, the Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sidney Alfred Alpert Lenore Beverly Schlenoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sidney Alpert, Father 12514 Davan Drive, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 06/28/05 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) <u>Judean Memorial Gardens</u> Olney, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease Years /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, the IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, Hyperlipidemia 1X Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed ,24b. Were autopsy findings available prior to completion of cause of death? Hypothyroidism 24a. Was an autopsy performed 2□ No Depression 1 Yes 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D 25344 06/27/05 #209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JUN 2 9 2005

Robert Ginsburg, M.D., 2415 Musgrove Road, Silver Spring, MD

Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 05 1- State Registrar Amended item #20b per fh/wicher/tijpa/95/d28ath 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 9:59 Florence Elizabeth Armstrong June 21, 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico 28686 Ocean Gateway Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 3/4/1951 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛱 F Yrs. 54 218-50-1230 Maryland Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County s 23a or 28a-f show 1 Yes 2 No Maryland Wicomico Salisbury Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 28686 Ocean Gateway 21801 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or Itams 11. Marital Status the Medical Examiner: Black, White, etc. within 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education grade completed) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Customer Service Representative Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fi Health and Mental H tam 27 Is markad otl othar traumatic evar Irvin Dallas Ruark Margaret Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at
Important: If itam 27 Is
any injury or othar trau
once. Angela Dawn Jarvis/daughter 9305 Calvary Circle, Salisbury, MD 21801 20b. Place of Disposition (Name of cometery, crematory or other place)
Springhill Memory 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/25/05 Hebron, MD * 4 ☐ Donation 5 ☐ Other (Specify) Garđens Signature of Funeral Service Licensee 22. Name and Address of Facility HOLLOWAY Funeral Home Professional Association Javid H. Compour 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mutus home **Physician** & mi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy detached for Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 TYes 2/NO Division of Vital To tha Hospital or Attanding Phyaician: within 24 hours after death.

To tha Funaral Diractor; After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 20500 30. Name and ad completed cause of death (Item 23a) (Type, Print) Suussuny CAMPILL ST 145 TRASSO VE gistrar's Signature 31. Date filed (Month JUN 2 3 2005 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 9:14 PM 2005 Frank Edward Blackwell 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 10/17/1934 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. Yrs. North Carolina 70 246-44-4640 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1≚Yes 2 □ No Aberdeen MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. South Rogers Street 21001 334 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1953-64 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☒ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Equipment Operator 8 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rena Mae Barringer Cletus J. Blackwell, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 727 Wiseburg Rd., Whitehall, MD 21161 June Naylor (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gardens 07/14/2005 Aberdeen, MD ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. 333 S. Parké Street, Aberdeen, MD 21001 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequent nce of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LONIC OGST disease 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Anoxia 24a. Was an Incontrolled Diabetes 2 No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

attending physician and for use as the burial-transit

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to the Hospital or Attanding Physician:

within 24 hours after deatl To tha Funeral Diractor:

permit. Pages 1
Department of H
Important: If ita
any injury or otl

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23a or 28a-f show Examiner must be notified at

I Hygiene.

Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

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Examiner Physician/Medical Be Completed by

IF FEMALE: 25. Was case referred to medical examiner? Medical Certification: To

1 ☐ Yes 2 No 27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

1 Inpatient

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number DO053568

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Thompson

Registrar

29a. Certifier

(Check only

1 4 2005

32 Registrar's Signature

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			1 - For State Registrar	State of Mary	•	artment of He		lental Hy	giene	ሰበ።	2205	_
	Physici /Medic	al	1. Decedent's Name (First, Middle, La Andrew			Blasdel		2. Date of De Month	05	2005	2229	Ю Рм
\$ ·	Examin Funeral	er	4a. Facility Name (If not institution, given The Johns Hopk 5. Social Security Number 6.5	ins Hospite	yrs. last birthday)	4b. City, Town, or Butimo		8. Date of Bir (Month, Da	rth	9. Birthp	place (State or For	reign
	Director		217-71-6348 Usual Residence of Decedent 10a. State 10b. County	1 M 2 F	Yrs. c. City, Town or Lo	6 13	TIOUTS WITH.	Jan. 2	22, 20	05 Mary		
	th the Mary or 28a-f sh	irector	Maryland Hartfor	d F	Edgewood	10f. Zip Code			10g. Citize	n of What Cour	1 ☐ Yes 2 ☐ X	No
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deps riment of Heath and Mental Pygiene. Importent: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other treumetic event, If a Modical Examination in Hilled at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	in U.S. 13.	21040 Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I Specify:		0- 14	d State Race - Americ Black, White,	can Indian,	
20-01717	d within 72 hours jiene. r than "natural the Moderal	Completed t	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 0	ducation	16a. Dece (Give lite. none	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of workin	ng	16b. Kind	of Business/In-		
ylana	12 should be filed withir h and Mental Hygiene. 7 is markad other than treumetic event, 11 c.M.	To Be C	17. Father's Name (First, Middle, Last Richard Douglas F	Blasdell			18. Mother's Name Donna Con	nway				
lore, mar	ages 1 and 2 sh ni of Health and t: If item 27 is rr / or other treum		19a. Informant's Name/Relationship (Richard D. Blasd 20a. Method of Disposition 1□Burial 2△Cremation 3□	lell (father	0b. Place of Disposemetery, cre	ng Address (Street al Buoy Ct. E osition (Name of matory or other place Ltan Crema	dgewood,	MD 210 Pate	40 20c. Loca	own, State, Zip	own, State	
Dallillo	permit. P Departme Importen any injury		4 □ Donation 5 □ Other (Special 21. Signification of Fine at Service Lice	nsee	2	2. Name and Address 2. Hudson S	s of FacilityAdve	nt Fun	eral a	& Crema	tion Ser	vio
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	et Sydi), such as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death 30 days	h
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter fundarlying Cause (Disease or injury	b. liver fai	lure	- (0)				1	30days	
,0070	cate be executed oblysician and the burial-transit	dical Examin	Cause (Disease of Injury that initiated events resulting in death) Last	c. Respiration Due to (or as a co		64 days						
O. DOX OC	The law requires that the death certificate attending physe been signed by the attending physbage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of print 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3[□Ectopic pregnancy □ Other (specify)			230	d. Date of delive Month	ery Day Year	
ecords, r.	equires that the sound by the sound be detacted	by	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	ınderiying cause give	n in Part I.	23e. Did t	\ <u>\</u>		ne cause of death?	
אוומו חבכם	n: The law re ficate has ber nr, page 2 sho	Completed	Of War and the median					1 Tes	psy ormed? 2 No	24b. Were auto prior to cor death? 1 Yes	psy findings availa npletion of cause 2 No	able of
VISION OF VIE	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	of 28c. Injury Work	at 2		dence 6)	
	ital or Atterns after destral Director	Certification:	3 Suicide 6 Could not be determined		At home, farm, st	reet, factory, office	2	28f. Location (City or To		Number or Rura	l Route Number,	
	o the Hosp Ithin 24 hou o the Funer	Medical	29a. Certifier (Check only one) 1 Certifying Pl Description 1 Medical Example 1 29b. Signature and title of certifier	hysician: To the best of m miner: On the basis of exa and manner stated.	y knowledge, deat imination and/or in	th occurred at the time envestigation, in my opi	inion, death occurre	and due to the ed at the time,	date and pl	id manner as st ace, and due to signed (Month,	the cause(s)	
	3		Jheodou 30. Name and address of person who	completed ause of death	(Item 23a) (Type,	WORES-	000	-	July	062	005	-
w.	Sta Registr		Theodora Sta 31. Date filed (Month, Day, Year)	V roudis 32. Registrar's S	Signature	Wolfe	street,	Datt	Imor	e, 141) 2128	_/
D١	-IMH 17 Rev 1/2	001	JUL 1 4 200	in the second	- 17							

Arlester, Barrow Baltimore. Maryland 21215-0036

		For State	State of Maryland / Depart		fental Hygiene	
		Registrar 1. Decedent's Name (First, Middle, Last).	Cenii	icate of Death	Reg. No.	005 23057
Physic		A CIPSTOR P	vaccow		June 25	2005 1:50 AM
/Medi Examir		4a. Facility Name (If not institution, give si	reet and number) 4th	o. City, Town, or Location of Death	4c. 0	County of Death
	*	Berlin Nursing a		to Berlin	u	Jorcester
Funeral Director		246 30-2163		Under 1 Year If Under 24 Hrs. In Inder 24 Hrs. In Inder 24 Hrs. In Inder 24 Hrs. In Inder 24 Hrs. In Index 2	8. Date of Birth (Month, Day, Year) 3 -/8-24	9. Birthplace (State or Foreign
show		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locati	on		10d. Inside City Limits
Mary B-f sh	tor	Mild. Worcest	er Berlin			1 ☐ Yes 2 ☐ No
with the M 3a or 28e-f	Funeral Director	10e. Street and Number	much street	10f. Zip Code 2 / 8//	10g. Citiz	en of What Country?
I E, INIAI y IAILU ZIZIO OOO s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hydene. Health and Mental Hydene. item 27 is marked other than "naturel; or items 23a or 28e-1 show other treumatic event, it a Medical Exercite constitute inclified at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Married 4 Divorced	1 ZHOS 2 No	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto Yes 2 Ale Specify:		4. Race - American Indian, Black, White, etc. Specify: 13/146
72 hou		15. Decedent's Educ (Specify only highest grade	ation 16a. Decedent	t's Usual Occupation d of work done during most of work	ing 16b. Kin	d of Business/Industry
filed within Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	NOT use retired) NOT use retired) NOT use retired)	7/1	ASONAM
ial y ially 4.14. 2 should be filed within and Mental Hygiene. Is marked other than eumatic event, Italy	To Be C	17. Father's Name (First, Middle, Last) Willie Bal	you	18. Mother's Nam	e (First, Middle, Maiden S Rouse	Surname)
C, IVIGITY 1 and 2 sho Health and N em 27 Is ma		19a. Informant's Name/Relationship (Type NAT/ITA DENI	e, Print) Grand- 19b. Mailing A	Address (Street and Number or Run	al Route Number City or	Town, State, Zip Gode)
Pages 1 and nent of Health nt: If item 27 iny or other tr		20a. Method of Disposition 1	20b. Place of Disposition cametery, cremate M.J. R. f.	proposery 6-2	9-05 /ful	ation - City or Town, State Lock, Md.
permit. Pages 1 Department of It Important: If ite eny injury or ot once.		21. Signature of Funeral Service License		ame and dr s of Facility	LEWIS N. U. 7180)	WATSON Funeral Home
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. Do not enter the cause on each line.	he mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		eart failui	2	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of):	reroscleratio	h 00-1	1
	i-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	ieroscierono	rearro	usease years
cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
icate be executed physician and sthe burial-transit	Exa	resulting in death) Last	Due to (or as a consequence of):			
cate b	edlcal	d				
OX O		IF FEMALE: 23 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy		23	3d. Date of delivery
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		topic pregnancy ther (specify)		Month Day Year
s that	by Pł	- I	ributing to death but not resulting in the unde	· · · ,		e contribute to the cause of death?
w requires to be signed should be			ctive pulmona	ry disease	1 ☐ Yes 2 ☐	No 3 Probably 4 Ponknown
e taw r has be	Completed	diabetes me	11/hs		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
The Tricate licate		has a second			1 ☐ Yes 2 ☑ No	1 Yes 2 No
VICAL Sician: Sertifical	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 ER/Outpatient		h (Check only one) ome 5 Residence 6	Other (Specify)
ig Phy ig Phy ler this	H	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury	
Attending ar death. ector: After by the fune	catlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes 2 No		
blor Att	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: Atler completely filled in by the funer	edical C		ician: To the best of my knowledge, death or er: On the basis of examination and/or invest and manner stated.			
To th withir To th comp	¥	29b. Signature and title of certifier	11 11	29c. License number (Oc		signed (Month, Day, Year)
\$100	1	Kustine M		C1 000679.		
Jaly		30. Name and address of person who con	mpleted caus a eath (Item 23a) (Type, Prin	nt) ASTAL HIGHUR	M. FELILLI	W. ISI AND DE 1940
St	ate	31. Date filed (Month, Day, Year)	32. Figistrar's Signature	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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Amend # AA Co H	12,29c & 11th Dept	31 : k i	per PHY 6/2	^{24/05} Please T	ype or Pri	nt in Bla	ick Ind	elible Ink	. Ensure	All Copi	es Ar	e Legi	ble.		
Amend #	#5 per FD	6/	24/05		State of M	aryland /	Depai	tment of F <i>ificate of</i>	Health and	d Mental	Hygiei	ne 🔵		20050	
AA CO H	balth De	pt	State Registrar 1. Decedent's Nam	ne (First, Middle, Last)	0	11	Cen	ilicate of	Deam	2. Date of	f Death	6/15/0] 5)5	3. Time of Death	
	Physici /Medio		Je 981	e.W.	15arn	je tt				Month	, /	Say S	Year	6A M	
	Examin		4a. Facility Name (If not institution, give s	street and number))		4b. City, Town, o				Ah M		1 fol	
	Funeral		5. Social Security N			ge (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 H		f Birth			lace (State or Foreign	
	Director		Usual Residences	5 0130 18	M 2□F	17	Yrs.	WOTHIS Days	Hours IN	037	f Birth Day, Yea 13/19	88		MD	
	yland		10a. State	10b. County		10c. City, T	own or Loc						11	Od. Inside City Limits	
	Be-f sl	Funeral Director	MD	Anne Arı	undel			Glen Bu	ırnie			a		1 ☐ Yes 2X No	
	with th	i Dir	10e. Street and Nu	ods Avenue				10f. Zip Code	21061		10g.	Citizen of t	What Coun US		
	death	nera	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decedent of h Yes, specify Cub		(Specify Yes o	r No-		e - Americ	an Indian,	
9600	within 72 hours after death with the Maryland ane. than "neturel; or iteme 23e or 28e-1 show to Madical Examinar roual be notified at	by	1 X Never Man	ried 2 Married 4 Divorced	1 Tes 2 15 If Yes, Give Year or Dates:	No		Yes 2X No			.,	Specif	TATI	hite	
15-(n 72 hours "neturei", edical Ex	lete		15. Decedent's Educify only highest grade	e completed)		6a. Decede (Give k. life. De	nt's Usual Occup ind of work done O NOT use retire	pation during most of (d)	working	16b	. Kind of B	usiness/Ind	lustry	
212		Completed	Elementary/Sect	ondary (0-12)	College (1-4or	5+)		Stude					Sch	1001	
pu	2 G 2 9	Be		(First, Middle, Last) Walker Bar	rnett. II	Т				Name (First, Mi			16)		
aryk	should be filed and Mental Hygi is marked other eumetic event, I	2		lame/Relationship (Ty			19b. Mailing	Address (Street					State, Zip	Code)	
,≅	s 1 and 2 should f Health and Men item 27 is marke other treumetic			W. Barnett	, III/Fat			Smith F	Road, Sa			218			
more	a no controllery, cromatory or other places International controllery, cromatory or other places											20c. Location - City or Town, State Annapolis, MD			
3alti	permit. Page Department of Importent: if any injury or once.		21. Signature of F	uneral Service License	00//		Ba	Parand Addre	ss sons,	P.A. Se	evern	a Par	k Fun	neral Home 21146	
	<u>0</u> 0 ≥ € 0		23a, Part I, Enter	the disease, or compli art failure. List only or	Cations that cause	d the death. [a Par	K, ML	Approximate	
•	Prysician /Medical Examiner		Immediate Cause disease or conditi resulting in death)	(Final on	(Relay	ine. 05Cd) s a consequen	NEC	robla						Interval Between Onset and Death FACERS	
3760,	ate be executed hysicien and he burial-transit	ical Examiner	Sequentially list or if any, I saumy to in cause. Enter Und Cause (Disease on that initiated event resulting in death)	onditions, in minimal at the control of the control	·	s a consequen	,								
.O. Box 6876	Attending Physicien: The law requires that the death certificate be rideath. ector: After this certificate has been signed by the attending physicie by the funeral director, page 2 should be detached for use as the but	by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	nt pregnant 2 months? No	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3 🗆 8	ctopic pregnanc Other (specify)	у				te of delive	ry Day Year	
rds, P	quires that n signed b aid be deta	d by Pl	Part II. Other signi	ificant conditions cor		but not resultin	g in the und	lerlying cause gr	ven in Part I.		Did tobacc	o use cont		e cause of death?	
Division of Vital Records, P.O.	sicien: The law require certificate has been sig irector, page 2 should b	Completed								- 1	Was an autopsy performed 2	2	Were autor prior to con death? t Yes	psy findings available inpletion of cause of	
Vita	ysicien: is certific director,	Be	25. Was case refe examiner?	1	lospital:			Ott	205	Death (Check o	/				
of	g Phys er this eral di	n: To	1 Yes 2	ath	28a. Date of Inju		Outpatient b. Time of	28c. Injur	ry at	g Home 5 28d. Desc)	
sion	ending F eath. or: After he funera	atio	1 Accident	5 Pending investigation	(MORITI, Da	ay rear/	Injury	M 1	Yes 2 □ No						
Divis	in Sir e	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In building, e	njury - At home itc. <i>(Specify)</i>	, farm, stre	et, factory, office			on (Street r Town, St		er or Rura	I Route Number,	
	e Hospitei 124 hours a 18 Funerei I	Medical	29a. Certifier (Check only one)	1 Certifying Phy: 2 Medical Exami	sicien: To the best ner: On the basis of and manner si	of examination	dge, death and/or inve	occurred at the ti estigation, in my o	me, date and pla opinion, death o	ace, and due to ccurred at the t	the cause me, date a	(s) and ma and place,	inner as stand due to	ated. the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and	d title of certifier	offnoe	ui) 1	my)	29c. Licens			29d. I	Date signe	6 (Month, L	Day, Year)	
			30. Name and add	dress of person who co	ompleted cause of	death (Item 23	a) (Type, P		eltima	re, v	w	212	20	/	
	Sta Regist		31. Date filed (Mo.	to 105		trar's Signature	2005	Bearing	B	Ante					

			Please	Ctate of Manuar						ie.
			For State	State of Marylar				Mental Hyg	iene	
			State Registrar	-41	Cer	tificate o	Death	2. Date of Deatl	g. ND 1	5 23059
	Physicia		1. Decedent's Name (First, Middle, La	Rebecca	Bo	0)0/440	10	Month	Day Y	fear 005 0135 M
	/Medic Examin	40.0	4a. Facility Name (If not institution, give	e street and number)	1.10	4b. City, Town	, or Location of Deat	<i>Q</i>	4c. County of	Death
			Peninsula Regi	onal Medical	Center	If Under 1 Yea	ar If Under 24 Hrs	8. Date of Birth		omico
	Funeral Director	,	217-30-7659	Sex 7. Age (In yrs		Months Day		(Month, Day,	3,1923	9. Birthplace (State or Foreign Country) Mary Jand
and	A ==	-	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Loc	cation				10d. Inside City Limits
Mary	-f sho	to	MD Wicon	nico	Sal	!chin	.1/			1 ☐Yes 2 ☐ No
ے چ	r 28a	lrec	10e. Street and Number	77.00	2001	10f. Zip Code	,7	10	g. Citizen of Wh	nat Country?
death with the Maryland	23a o	al D	200 Civi	c Avenu	0	2	1804		US	s A
r dea	ems	iner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent o Yes, specify Co	f Hispanic Origin? (Suban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Black,	- American Indian, White, etc.
36 safter	P B	Y.F.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 1 No If Yes, Give	1	□Yes 217N	lo Specify:		Specify:	01 1
5-0036	le E	ed b	15. Decedent's E	Year or Dates:	16a Deced	lent's Usual Occ	unation		16b. Kind of Busi	Black
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3	giene.	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-407 5+)	Day	Care	Provid	der 1	Privat	e Residence
	al Hygi d other vent, 1	Be (17. Father's Name (First, Middle, Last)	/			ne (First, Middle, N	faiden Sumame)	
yla ould t	Mental arked o atic eve	2	Thomas H	BOUVMAN	, SR.		Mary		1 Tru	
Maryland			19a. Informant's Name/Relationship	<i>"</i>	0	g Address (Stre	et and Number or A	iral Route Number,	City or Town, SI	ate, Zil Code) 20904
a lan	Health am 27 ther tr		Maxine Pal 20a, Method of Disposition	Mer Lower	Place of Dispos	t Cast	leway U.	N+101-	7 211VEV 20c. Location - C	c Siring MD.
JOr ages	or or o		1 DBurial 2 □ Cremation 3	Removal from State	cemetery, crem	natory`or other p	1 1 / /	18/05	SI AL	0 / l = 000
Baltimore,	Department o Importent: If any injury or once.		4 □ Donation 5 □ Other (Special Signature) of Funeral Service Lice	7		NuS (PM . Name and Add	tress of Facility	20/05	STIMIC	chaels MD.
Ba	Depai Impo any ir		Janello,	C. Stenr	, H	enRY	Funeral	HOME, P	A. ubrida	a MD 2/6/12
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xecut	ician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (o. as a conse	quence of):					
760, te be execu	sician and e burial-tra	calE		Cole	tea					
X 687	attending physical							_		
Box eath cert	use (by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1□Live birth 2□Fet		Ectopic pregnar	204		23d. Date	,
. 0	ne atte ed for	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of		Other (specify)			Monti	h Day Year
P.O	igned by the atte be detached for	Phy	9 Unknown				1.0.11	One Didash		who had he against a death 0
S,	signed bed	by	Part II. Other significant conditions	contributing to death but not re	sulting in the un	nderlying cause	given in Part I.		iacco usa contrio is 2 □ No 3	to the cause of death?
of Vital Records, Physicien: The law requires t	been si	Completed						-		
Rec	has Je 2	mpl						24a. Was ar autopsy perform	y prided? dea	ere autopsy findings available or to completion of cause of ath?
al B	certificate ha rector, page	e Co	25. Was case referred to medical	1			OC Place of Da	1 Yes 2	1 I	Yes 2 No
of Vita	is certific director,	To Be	examiner?	Hospital: 1 Impatient 2	☐ ER/Outpatien	t 3 DOA	Thor	tin (<i>Cneck only one</i> fome 5 ☐ Reside	4	(Specify)
of of	æ ⊒	I.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In		28d. Describe ho		
Vision	fu Africa	atlo	1 ☐ ★atural 5 ☐ Pending 2 ☐ Accident investigation	en .	mjury		Yes 2 No			
Division or Attending	irecto	Certification:	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre	eet, factory, offic	9	28f. Location (Str City or Town	reet and Number , State)	or Rural Route Number,
O offer	urs af							1		
Hosp	within 24 hours after deatt To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	lowledge, death lation and/or inv	occurred at the restigation, in m	time, date and place y opinion, death occi	e, and due to the ca urred at the time, da	use(s) and manrate and place, an	ner as stated. d due to the cause(s)
ro the	vithin Fo the	Me	29b. Signature and title of certifier			29c. Lice	ense number	29	d. Date signed ((Month, Day, Year)
	71.0			0	PO	40	10574	10 6	1/21/	105
			30. Name and address of person who			Print)	51. 5AC		ms	
			SIMONA ENG		E. C.	1110/1 -	51. SAC	usouz i	///	
0.7	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature Salara	And		~		

			Please	Type or Print in				-		Legible.	
		4	For State	State of Maryla				Mental Hyg	liene		
			Registrar		Ce	rtificate of	Death	-	eg. No.	2005	23060
	/sicia	n	1. Decedent's Name (First, Middle, Las	"Rober	ta	BROG	KS	2. Date of Dear Month	Day	Yeer - 0.5	2 35 P M
	ledica amine		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death	1		County of Dea	th
			5. Social Security Number 6. Se		s. last birthday	If Under 1 Year	Storv If Under 24 Hrs.	8. Date of Birth		Fa/bo	tholace (State or Foreign
Fun Direc		6	213-16-8840 1	□M 2127 8	2 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day)	() ()		thplace (State or Foreign ountry) akyland
and		-	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or L	ocation					10d. Inside City Limits
Maryland -f show	E E	ō	MD Talb	ot	E	ston					1 No
7 £ 8	a not	irec	10e. Street and Number)		10f. Zip Code		1	l0g. Citi	zen of What C	ountry?
death with the ms 23a or 28a	distr.	Funeral Director	220-Glen		enue	0	2/601			U51	4
r deg	5	Ine	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		 Race - Ame Black, Whi 	erican Indian, te, etc.
iore, Intervially 21213-0030 ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If Item 27 is marked other then "nature!, or Items 23a or 28a-f show	Ezami	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ 1√0 If Yes, Give Year or Dates:		1 ☐ Yes 2 D No	Specify:			Specify: B	lack
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Athin Men	is Me	mp	Elementary/Secondary (0-12)	College (1-4or 5+)					0.	blic	Salari
filed with Hygiene. other ther	받		17. Father's Name (First, Middle, Last)	5 7	150	hool	18. Mother's Nan	ne (First, Middle, i			School
ld be ental ked o	O OV	To Be	Howard	Hubbard			DORO			comb	
2 shou and M	umat	⊢ .	19a. Informant's Name/Relationship (7	/ -1	19b. Mail	ing Address (Stree	and Number or Ru				
and 2 and 2 lealth a m 27 is	er tra		Albert BRO		_302	- HOPKI	ns Place	e Eas	ton	J, Mak	yland 21601
of He	r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b	. Place of Disp cemetery, cre	osition (Name of matory or other pla				tion - City or	11.7
Pag tment tent:	injury o		`4 □ Donation 5 □ Other (Specify) W		in Mem. F					naryland
Dailino permit. Pages Department of Importent: If I	any in		21. Signature of Funeral Service Licen	C. Hen	ء م ربعب	2. Name and Addre	ess of Facility Funero hington	1 HOME	11 Po	A. brida	e, MD.2/613
			23a. Part1. Enter the disease, or companies of the art failure. List only	olications that caused the de	ath. Do not en	ter the mode of dyi	ng, such a ardiad	or respiratory arr	est,		Approximate Interval Between
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oU, be execut ician and	ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as a cons	equence of):			<u>.</u>			
S, F.O. BOX 08/00, es that the death certificate be executed igned by the attending physician and	ne bur	cai	(d			·				
Certificate	as th	Med	IF FEMALE:								
death cer	or use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 Fe	etal death 3	⊒Ectopic pregnanc	:y		2	23d. Date of de Month	livery Day Year
he de	ched f	hysician/Medi	1 ☐ Yes 2 ♠No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	rdeath 5	Other (s <i>pecify)</i> _					
ords, P.O. requires that the	deta	by Ph	Part II. Other significant conditions of	ontributing to death but not r	esulting in the	underlying cause gr	ven in Part I.	23e. Did tol	bacco u	se contribute t	o the cause of death?
w requires	nld be		Chromic per	sal FAilur	re			1 □ Ye	es 25	2 No 3□P	robably 4 Unknown
S × C	C/I	ompieted	DiAbetes m	ellitus				24a. Was a		prior to	utopsy findings available completion of cause of
The The	раде	Com						perform	med? 2 € No	death?	2 No
VITAL P Ilcien: Th certificate	Ö,	Be (25. Was case referred to medical examiner?	Hamital		100		ith (Check only on			
- × ×	- 1	2	1 Yes 2 SNo	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatie	III 3 DOA		lome 5 Reside		•	poity)Hospice
	fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □No	200. 20000 1	ow inqui	, 00041104	
UIVISION OF OF A STEEL GOATH. Director: After th	by the	ifica	3 Suicide 6 Could not be determined		home, farm, si	reet, factory, office		28f. Location (St City or Town	treet and	d Number or R	ural Route Number,
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To the Hospitel or within 24 hours af To the Funerel D	etely fill	edical	29a. Certifier 1. Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, dea ination and/or in	th occurred at the to rivestigation, in my	ime, date and place opinion, death occu	, and due to the carred at the time, d	ause(s) late and	and manner a place, and du	s stated. e to the cause(s)
To the	omple	Me	29b. Signature and title of certifier	4			se number			e signed (Mon	
- 5	0		> Muhael 1	Juhans		D 3	31867	A trap to the same of the same	6/-	27/05	
			30. Name and address of person who		tem 23a) (Type	, Print)	31867 AVENI			0 1	21/:-
			MICHAEL J. FI. 31. Date filed (Month, Day, Year)	SHER MY 32. Repostrar's Sig	2117	uleurla	ANGNI	ie ens	TON	ind	2,001
	Sta										

UNK DEBORAL ELLISON BUREH 05-04446 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RKD State of Maryland / Department of Health and Mental Hygiene DEBORAH ELLISON 1- For State Unpend Item 23a,27,28a-f per mee 686 at 8-0160 95th tas Reg. No 2 U () 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JULY 2005 2:17 P. M Deborah Ellison Burch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 27279 THREE NOTCH ROAD MECHANICSVILLE ST.MARYS If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖺 F 32 Yrs. 235-13-4817 August 25, Director Ohio Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Saint Mary's Mechanicsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 27279 Three Notch Road 20659 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race · American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 🖔 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married ŏ Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White ģ 3 Widowed 4 Divorced "nstural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 Restraunt Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Zona Blankenship John Ellison and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If itam 27 ls P.O. Box 744, Charlotte Hall, Maryland 20622 Charles David Burch / Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If sny injury or once. ŏ 4 ☐ Donation 5 ☐ Other (Specify) July 5, 2005 Alexandria, Virginia Metropolitan Crematory permit 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.o. Box 270, Leonardtown, Maryland 20650 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Methadone Intoxication **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inmodula cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

Tes 2 No 24a. Was an autopsy performed? 1 Yes 2 🗆 No funeral director, 25. Was case reterred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 1 Yes 2 □ No After this 28a. Date of Injury **Found**, Day Year) **7-1-05** 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred unk Certification: 1 Natural 5 Pending Found 1:54 after death.
I Director: Aff 1 ☐ Yes 2 No investigation 2 Accident 6 X Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 27279 Three Notch Rd. Mechanicsville, Three Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or Found at home 24 hours a 8 Funeral C filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

MARGARITA

31. Date filed (Month, Day)

s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCME

JULY 2,2005

111 Penn Street Baltimore, Maryland 21201

		•	For State Registrar	State of	Marylar	nd / Dep <i>Ce</i>	artmen ertificat	t of H	lealth a	and M	lental Hy	giene Reg. No.	005	5	2306	62
	Dhyoisi	20	1. Decedent's Name (First, Middle,								2. Date of De Month	ath Day	y Ye	ar	3. Time of D	Death
	Physicia /Medic		Florence B								June :		2005		8:29P	, M
	Examin	er	4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	of Death			County of D			
			18809 Sparkling 5. Social Security Number		ive - 7. Age (In yrs.			mant 1 Year	OWN If Under	24 Hrs.	8. Date of Bir		Montgo		ry place (State or	Foreign
П	Funeral Director		062-20-1479	1 ☐ M 2 🗓 F	89 89	Yrs.	Months		Hours	Min.	July 2	Year)	915	Coun	orgia	roraigir
			Usual Residence of Decedent													
	rylan ihow	_	10a. State 10b. County			ty, Town or L								11	0d. Inside City	
	Ba-f s	Director		omery	G	ermant								\perp	1 Tes	2 <u>A</u>) NO
	within 72 hours after death with the Maryland ene. then "naturel", or llems 23a or 28a-f show the Medical Examinar must be notified at		10e. Street and Number 18809 Sparkli	no Water	Drive.	Apt 1	10f. Zip		0876			_	izen of Whai United		-	
	eath v	Funeral	11. Marital Status	12. Was Dece						gin? (Spe	ecify Yes or No		14. Race - A			
	fter d r Item iner	Fun	1 Never Married 2 Marrie	Armed For	ces? 2. XNo						ecify Yes or No Rican, etc.)		Black, V	White,	etc.	
93	ol', o	þ	3 Widowed 4 □ Divorced	If Yes, Giv Year or Da	e ites:		1 🗌 Yes	2[X]No	Specify:				Specify: E	31ac	2K	
21215-0036	72 ho natur lical	Completed	15. Decedent' (Specify only highes	s Education	-	16a. Dec	edent's Usu e kind of wo DO NOT u	al Occupa	ation during mos	t of work	ng	16b. Ki	ind of Busine	ass/Inc	dustry	
2	ithin en.	npl	Elementary/Secondary (0-12)	College (1	-4or 5+)								<u> </u>		- 1	
2	iled w lygier her tl		10 17. Father's Name (First, Middle, L	act)		Mac	hine	Oper		are Name	(First, Middle			it i	Industr	<u>-y</u>
Maryland	t be find the find th	Be	Charlie Cain	.431/							aunder		Sumame)			
Ž	id Me mark matic	은	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mai	ling Address	(Street a			al Route Numb		or Town, Sta	te, Zip	Code)	
<u>s</u>	Ith ar 27 is r treu		Rosemary Spellm		hter		_				rive,#	-)876
ē,	f Healitem		20a. Method of Disposition		1 .	Place of Disp	position (Na	me of	(a)	C	Date	20c. Lc	cation - City	or To	wn, State	
Ê	Page ient o nt: If ry or									6-02	-05	Germa	antown	ı, N	1ary1ar	ıd
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Importent: If item 27 is marked other then "naturel, or litems 23a or 28a-f show any injury or other treumatic event, I'm Medical Examinat must be notified at once.		1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) All Souls Cemetery 06-02-05 Germantown, Maryland 1. Signature of neral Service Licensee 26401 Ridge Road, Damascus, Maryland 20872													
			23a. Part1. Enter the disease, or shock or heart failure. List of	complications that conty one cause on e	aused the dear	th. Do not e									Approximate Interval Between	/een
B	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													eath
	/Medical		Immediate Cause (Final disease or condition resulting in death) Hepatic failure Due to (or as a consequence of):													
b	Examiner	_	Sequentially list conditions, if any, leading to immediate	D	toma									4		
	ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury		or as a consec	each.										
	and and al-trar	xan	that initiated events resulting in death) Last	G,	I TITIS or as a consec									-		
8760,	ficate be executed g physician and is the burial-transit			д Нуре	rtensi	ve Hea	art Di	seas	e							
687	ificate g phy: as the	edic														
Вох	death certifica attending ph d for use as th	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnirth 2 Peta		□Ectopic p	regnancy	,				23d. Date of			
	ie deat the attr	sicla	in the past 12 months?		ant at time of o		Other (s						Month		Day Ye	ear
0.0	that the de ed by the detached	Phy	9 Unknown				and a defendance		In Book I		22° Did			i - i - ih		nath?
Vital Records,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditio	ns contributing to de	eath but not res	suiting in the	underlying o	ause giv	en in Part i						ne cause of de pably 4 ∭Ur	
00	s beel	Completed									24a. Was				psy findings av	
Be	The tay te has age 2	dmo									auto perfo 1 ☐ Yes	psy ormed?	prior deatl	h?	mpletion of cat 2□ No	use of
ta		O	25. Was case referred to medical						26. Place	of Death	(Check only		1 .0	103	20110	
	Physicien: r this certifica ral director, i	To B	examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 🔲	npatient 2	ER/Outpation	ent 3 D	Oth	er: 4 🗌 Nu	ırsing Ho	me 5 ∑ Resi	dence	6 Dother (Specify	y)	
on of	ding After fune	Certification:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investig		of Injury h, Day Year)	28b. Time Injury	of :	28c. Injun Wor	y at		28d. Describe					
Division	or Attending after death. Director: After in by the fune	fical	3 ☐ Suicide 6 ☐ Could n	ot be 28e, Place	of Injury - At h	ome, farm, s					28f. Location (Street and Number or Rural Route Number,					oer,
<u>S</u>	Ditte	erti	4 Homicide	buildir	ng, etc. (Speci	fy)		•			City or To	wn, State)			
	To the Hospitel or Att within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical I	g Physician: To the Examiner: On the ba and mann	asis of examina	owledge, dea ation and/or	ath occurred investigation	at the tin	ne, date an pinion, dea	nd place, th occurr	and due to the ed at the time,	cause(s) date and	and manne I place, and	r as st due to	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier		^		29	c. Licens	e number			29d. Dat	te signed (M	fonth,	Day, Year)	
•			> Twoms	vs V.	Jose	14		D004	7330			June	e 28,	200)5	
	η.		30. Name and address of person	who completed caus			e, Print)			-	_1					
	V		Thomas V. Jo						urive	, Ko	ckville	, ма	.ryıan	<u> </u>	20852	
	Sta Registi		31. Date filed (Month, Day, Year) JUN	3 0 2005	egistrar's Sign	L A	April	MAR.								

			For State Registrar	State of M	larylan		artmen rtificate					_	กกต	23063
	Physici	an	1. Decedent's Name (First, Middle	, Last)							2. Date of De	ath Day	Yea	3. Time of Death
	Physici /Medic			id Allen Br		Sr.					June 2	9, 20	005	10:33 P M
	Examin	er	4a. Facility Name (If not institution)				Location of	of Death			County of D	
			42919 St. John' 5. Social Security Number		ge (In vrs.	last birthday)		1ywc	od If Under	24 Hrs.	8. Date of Birt		int M	
	Funeral Director		218-98-7193	1⊠M 2□F	go ()	43 Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		Birthplace (State or Foreign Country)
	D		Usual Residence of Decedent								nagase z	-1, 17	01 110	II y land
	arylar show	_	10a. State 10b. County			ty, Town or Lo								10d. Inside City Limits
	Sa-f	Director	Maryland Saint N	larys	I	Hollywoo								1 ☐ Yes 2 ☑ No
	with t	Ö	10e. Street and Number				10f. Zip					10g. Citiz	en of What	Country?
	me 23	Funeral	42919 St. John's F	12. Was Deceden	t Ever in U	.S. 13.		0636 lent of Hi	ispanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	- 1	USA 4. Race - A	merican Indian,
9	or ital		1 ☐ Never Married 2 🔀 Marr			ĺ	lfYes,spec 1 ☐ Yes 2				Rican, etc.)	1	Black, W	
203	72 hours eiter death with the Maryland natural', or itema 23a or 28a-f show itsal Examinar must be motified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			Till Yes 2	2 2 1 NO	Specify:				Specify: W	nite
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b	e filed within al Hygiene. other than ' vent, the Me	Be C	17. Father's Name (First, Middle,	Last)						er's Name	(First, Middle,			
/lar	should be ind Mentells marked o	To E	Franklin Henry Bro	ooks					Mary	Blan	che Hear	d		
Maryland 21215-0036	C1 (0 -= 65		19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	I Route Numbe	er, City or	Town, State	a, Zip Code)
	of Health Item 27 other tr	1	Shirley Ann Brooks 20a Method of Disposition	s / Wife	20h E	42919 Place of Dispo			Road,		ywood, Ma			
Baltimore,	permit. Pages: Depertment of It important: if Ite any injury or ot	3	1 Burial 2 XX remation		• °	emetery, crer	natory or of	ther plac	, (or Town, State
臣	srtmer ortant injury		4 □ Donation 5 □ Other (S)21. Signature of Funeral envice		Met:	ropolita	n Crem 2. Name and				, 2005	Alexa	ındria,	Virginia
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			23a. Part1 Enter the disease, or shock, or heart failure. List	complications that cause	d the deat								050	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or a	s a conseq	uence of):			V mar		prim	265		10 /400/103
	LAGITITICI	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or a	2 000000	uanna of):		UN	From	V V.	100 100		-	
	nsit	Examiner	Cause (Disease or injury	Due to (or a.	s a conseq	derice or).						•		
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9	ertifica ling ph e as t	ed	IF FEMALE:											
Вох	eeth certific ettending p I for use as I	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	Ideath 3 ☐	Ectopic pre					23	d. Date of o	delivery Day Year
P.0.	thet the de ted by the e detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	u io emii ii	eath SE	Other (spe	өспу)						
	law requires thet the as been signed by th 2 should be detache	by Ph	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did to	bacco us	e contribute	to the cause of death?
Vital Records,	w require been sig should b		n	me							1 🗆 Y	′es 2 🗀	No 3 🗆	Probably 4 Unknown
ecc	e law re has be	Completed									24a. Was autop		24b. Were	autopsy findings available o completion of cause of
E =	Th ate pag	Con									perfor	rmed? 2.Z.No	death'	?
Vita	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				0+-		-	(Check only o			
of	Phys this al dii	To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 □ Inpat	and the same of	ER/Outpatien 28b. Time of		A Re Injury	4 Nu		ne 5 X Resid			pecify)
O	Attanding I r death. ector: After by the funer	tlon	1 Alatural 5 Pending		ay Year)	Injury	М	Bc. Injury Work 1 □ Y	(? ∕es 2∐i		.00. 50001150 11	low injury	occurred	
Division of	r Attano er death rector: by the	Certification;	3 Suicide 6 Could r	ned 289. Place of II	ijury - At ho tc. <i>(Specif</i>)	ome, farm, str	eet, factory,	, office			28f. Location (S City or Tow		Number or	Rural Route Number,
Ö	itafor rs efte al Dir ed in	Cert	- Indinional	building, e	ito. (Opecii)	y) 				ž.	City of Tow	m, State)		
	To the Hospitat or Attand within 24 hours effer death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the bes Exeminer: On the basis and manner s	ot examina	wledge, death tion and/or inv	occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, a th occurre	and due to the c ed at the time, c	ause(s) a	nd manner lace, and d	as stated. ue to the cause(s)
	To the within To the compl	Me	29b. Signature and titte of certifier						number			29d. Date	signed (Mo	nth, Day, Year)
			· IX	attend	ting	-		Do	055	568	2	6	0 (70	105
10	J7/1/		30. Name and address of person of thomas M.	who completed cause of Wilkinson	death (lt	23a) (Type,	Print) 415	Thr	ee No	itch	Rd 20	52	Califi	lost unia mb.
	Sta Registr	6.00	31. Date filed (Month, Day, Year)	32_Regist	rar's Signa									
		- 22	10F 9	COOL TIME	~ /4									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JUNE 3:50P 24 2005 DUANE ALLEN BURCH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY N.I.H. CLINICAL CENTER BETHESDA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1**∑**M 2□ F Yrs MICHIGAN 43 Director 386-80-5099 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County Show s 23e or 28a-f show 1X Yes 2 □ No Directo VA. NONE VIRGINIA BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1219 BELLS RD. 23454 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rthen "neturel", or Items 11 Marital Status Black, White, etc. Tyes 2 No 1989-f Yes, Give Year or Dates: 2005 within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: Specify: ۵ 2005 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or5+) **DEFENSE** 12 U.S. NAVY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If item 27 is marked o any injurgor other treumatic eve BURCH SIMINGTON 0. VTRGTNTA 2 LeMOYNE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1219 BELLS RD., VIRGINIA BEACH, VA. 23454 BURCH/WIFE KATHRYN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 16-28-2005 RIVERDALE, MD. 21. Signature of Funeral Service Ligensee 22 Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P. 5801 CLEVELAND AVE., RIVERDALE, MD. 20 any ir - Mambus M00091 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ersis **Physician** /Medical Due to (or as a consequence of): tspergillosis **Examiner** onavu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed Stic and I-tran resulting in death) Last Due to (or as a consequence of): physician a s the burial-1 Division of Vital Records, P.O. Box 68760, Physician/Medicai attending | 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the al 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has rmea? 2□No certificate Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 1 Tyes this ieral Director: After the 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 9+1 ame and address of erson who complete cause of death (Item 23a) (Type, Print) Stop Barneon 10 CENTER DRIVE, BETHESDA MD 20892 32 Registrar's Signature 31. Date filed (Month, Da Year) State 29 2005 Registrar

				Department of Health and I	-	_				
			1 - State Registrar	Certificate of Death	Reg.	N2005	23065			
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death			
	/Medic	al	BERNARD L. BROWN	JR. 4b. City, Town, or Location of Death		26, 2005 4c. County of Death	6:30 P M			
	Examin	er	4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL	CLINTON	1	PRINCE G	FODCEC			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		8. Date of Birth (Month, Day, Ye	9 Righ	place (State or Foreign ntry)			
ı	Director		579-50-3457 ¹ X ^M ^{2□ F} 67	Yrs. Months Days Hours Min.	AUG. 28,	1937 WA	SH. D.C.			
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tot	wn or Location			10d. Inside City Limits			
	Mary a-f sh	tor	MD. PRINCE GEORGES	FORESTVILLE			1∰Yes 2□No			
	th the or 28s	Oirec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?			
	s 23a	ral	2107 TIBER DR.	20747	7 7 7	U.S.A.	4 - 41 -			
10	ter de	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No 1061	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	14. Race - Ameri Black, White,				
8	ours a	l by	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes, Give Year or Dates: 1967	1 ☐ Yes 2 👿 No Specify:		Specify: WH	ITE			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. kthar than "natural", or Itams 23a or 28a-f show ant, It's Medical Exartiral coust be routfled at	etec	15. Decedent's Education 16: (Specify only highest grade completed)	a. Decedent's Usual Occupation (Give kind of work done during most of work	king 16b	. Kind of Business/Ir	dustry			
12	within ene. than	дшо	Elementary/Secondary (0-12) College (1-4or 5+)	iife. DO NOT use retired) REPAIRMAN		TELEPHONE	CO.			
	e filed Il Hygi other	Se C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid		00.			
ylar	ould by Menta arkad atic en	To E	BERNARD L. BROWN	E'	THEL B	ICKSLER				
Maryland	12 sho		19a. Informant's Name/Relationship (Type, Print)	b. Mailing Address (Street and Number or Ru			Code)			
	1 and Health		MAUREEN BROWN/WIFE 2 20a. Method of Disposition 20b. Place	107 TIBER DR., FORES'		 ZU/4/ Location - City or Telescope 	own, State			
JOE L	Pages ent of nt: If it		1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	ery, crematory or other place) BERS CREMATORY 6-28-		IVERDALE,				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, Ite Mod cal Exarcine in ust be routified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility						
<u> </u>	88 = 88		100091		., RIVERDA	LE, MD. 20	0737			
П	3		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one close on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death			
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Mioma		Como				
Н	Examiner		Due to (or as a consequence	1,0011						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):						
	ecuted and transi	Examiner	C	-A.						
760,	te be executed ysician and le burial-transit	cal E	Due to (or as a consequence	, 01).						
687	# 5 6		d			1				
Вох	Physician: The law requires that the death certilical this certilicate has been signed by the attending phyral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal deat	th 3 Ectopic pregnancy		23d. Date of deliv-				
П	e dea the att	sici	in the past 12 months? 1	5 Other (specify)		Month	Day Year			
Δ.	ires that the death signed by the atte d be detached for	Ph)	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to t	he cause of death?			
rds,	quires n sign ald be				1 🗆 Yes	2 No 3 Prot	oably 4 Unknown			
Vital Record	law requir as been si 2 should	Completed			24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of			
Ä	The lavate has	Com			performed	? death?	2□ No			
Vita	ysician: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?		th (Check only one)					
of	Phys r this ral dir	2	1 Yes 2 ER/C		ome 5 Residence 28d. Describe how in		ý)			
on	Attanding Phyrideath. actor: After thi	ation	1 atural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Time of 28c. Injury at Work? M 1 Yes 2 No		1. ,				
Division	l or Attandi after death. Diractor: A	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	arm, street, factory, office	28f. Location (Street City or Town, St		al Route Number,			
	urs aft rral Di									
	To the Hospitel or Attenswithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifler 1 M Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	je, death occurred at the time, date and place ind/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)			
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29cr license number	29d.	Date signed (Month,	Day, Year)			
}	1141) For allow	V19033	5 4	10/27/0	5			
	(1, ,		30. ame and address of cropt the completed cause of death (Item 23a	(Type, Priet)	TAIRAI	Water M	1120736			
	Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Jev vall 18"	201.0	11 MIND IN	4 10 103			
	Registr		JUN 2 9 2005 House 15.	Sparke .			_			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** June 22 2005 4:00P Joseph Bossowick George /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Manor Care Potomac Montgomery If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min. 1 X M 2 □ F Director FEB. 14,1917 88 New York 110-07-4190 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a, State show y or other traumatic event, the Modical Examiner mat be notified 1X Yes 2 ☐ No Director Florida Palm Beach Palm Springs 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code WITH United Staes of America 725 Lori Drive #309 33461 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status o filed within 72 hours after de l'Hygiene. Othar than "natural", or Itam Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 1942-45 Completed 6b. Kind of Business/Industry United States 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Postal Service 12 Clerk Pages 1 and 2 should be filed went of Health and Mental Hygie and: If itam 27 is marked other? 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Zuflacht Max Bossowick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If itam 27 is
any Injury or other trau 9317 Crimson Leaf Terrace, Potomac, MD 20854-5490 Arlene Sambur - Daughter 20b. Place of Disposition (Name of cometery, crematory or other place Lake Worth Memory Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Surial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) 06/26/05 Lake Worth, Florida 22. Name and Address of Facility
Danzansky Goldberg Memorial Chapels, Inc. 21. Signature of Funeral Service Wornald. 1170 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis
Due to (or as a consequence of): /Medical Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4 Pregnant at time of death P.0. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 XNo 24a. Was an certificate has autopsy performed? 2 💢 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 XNatural 2 ☐ Accident 5 Pending death. 1 Yes 2 No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a a Funarel I 29a. Certifier cal 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner sitated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific Q H0051280 June 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, \rint) 9715 Medical Center Drive, Ste. 201, Rockville, MD 20550 Anushiravan Dadgar, D.O. 2. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 9 2005 Registrar

			For	State of M	aryland				ınd Me	ntal Hygi	ene		
			1 - Stata Registrar			Cei	tificate of	Death			1. No2 () ()	5	23067
I	Physicia	an	1. Decedent's Name (First, Middle		Bro	T.722				Date of Death Month	6, 200	ear	3. Time of Death
	/Medic	al	Gladys 4a. Facility Name (If not institution	Mogck		WII	4b. City, Town,	or Location of		June 2	6, 200 4c. County of		2:32 a ^M
	Examin	er						nce Fre		rk		lver	· L
	Funeral		Calvert County 5. Social Security Number	6. Sex 7. As	ge (In yrs. la	ast birthday)	If Under 1 Year	If Under 2	24 Hrs. 8	Date of Birth (Month, Day,		. Birthp	lace (State or Foreign
L	Director		578-28-7423	1 ☐ M 2 💢 F	91	Yrs.	Months Days	Hours	Min.	lay 21,	1914 M	ary.	länd
	and		Usual Residence of Decedent 10a, State 10b, County	,	10c. City	, Town or Lo	cation					1	0d. Inside City Limits
	Manyli f sho	tor		lvert			rederick	•					1 ☐ Yes 2 ☑ No
	r 28a	Directo	10e. Street and Number	2.401.0			10f. Zip Code			10	g. Citizen of Wh	at Cour	ntry?
	th with	al D	85 Hospital	Road			20)678 .			U.S.A	A.	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13. \	Was Decedent of f Yes, specify Cul	Hispanic Orig ban, Mexican,	jin? (Specif , Puerto Ric	y Yes or No- can, etc.)	14. Race - Black,	Americ White,	
36	rs afte	by Fı	1 ☐ Never Married 2 ☐ Married 3 🎖 Widowed 4 ☐ Divorced	If Yes, Give ZX	No		1 ☐ Yes 2 🙀 No	Specify:			Specify:	wh	ite
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or terms 23e or 28e-f show event, the Medical Evanination for cilifical at	ted t	15, Deceden	nt's Education		16a. Deced	dent's Usual Occu	pation		11	Sb. Kind of Busi		
212	thin 73	ple	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or	5+)	(Give	kind of work done DO NOT use retire	ed) during most	of working				
	filed withi Hygiene. other then	Completed		2		au	thor / a	rtist			literat		/ music
Maryland	ed fall	Be	17. Father's Name (First, Middle,	_				18. Mother	r's Name <i>(F</i> Frar	First, Middle, Ma	iden Sumame) Hardes		
<u> </u>	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 Is marked o eny injury or other traumatic eve ones.	To	Frederic			10b Mailir	ng Address (Stree	t and Number					Codel
<u>s</u>	d 2 st th and t7 Is r traur		Eleanor Janes				O. Box				21797	ate, zip	C009)
	t and Health tem 27		20a. Method of Disposition	, BIBCCI	20b. Pl		sition (Name of natory or other pla		Date		c. Location - C	ity or To	wn, State
E C	Pages nent of ont: If its ury or o		1 ☐ Burial 2 🏹 Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from State Specify)	,		tan Cre	I .	6/27	/05	Alexandı	cia.	VA
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Sign por of Funeral Service	License	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		. Name and Addr						
m	Depared Important Importan		Dryan	1 Tell	back) E	Rausch Fi	meral	Hone	P.A.,	Owings	, MD	20736
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cause t only one cause on each	d the death line.	. Do not ent	er the mode of dy	ing, such as c	cardiac or r	espiratory arres	t,		Approximate Interval Between
1	hysician		Immediate Cause (Final disease or condition	_ a	TRIA	96	FIBR	ILLR	7161	W.			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequ	ience of):							
8		ē	Sequentially list conditions,	b. Due to (or as	s a cons	ence of):						_	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	use. Enter Underlying ause (Disease or injury at initiated events									
o	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as	s a consequ	ence of):							
8760	ate be nysicia he bu	Physician/Medical		d									
9	ertifica ling ph e as t	Med	IF FEMALE:		,						1		
Вох	eath certific attending pl	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pregnand	су			23d. Date Month		ry Day Year
o.	that the de ted by the a detached t	ysic	1 □ Yes 2 5∕4 No 9 □ Unknown	4□Pregnant a 9□Unknown	at time of de	atri 5	Other (specify)						
<u> </u>	igned by be deta	by Ph	Part II. Other significant condition	ions contributing to death	but not resu	Iting in the u	nderlying cause g	ven in Part I.		23e. Did toba	cco use contrib	ute to th	ne cause of death?
<u>rds</u>	w requires been sign should be						·			1 🗌 Yes	2 Z No 3	☐ Prob	ably 4 Unknown
Records,	aw re	Completed								24a. Was an autopsy			psy findings available appletion of cause of
		mo								performe	ed2 dea	ath?	2 No
Vita	ysicien: Th is certificate director, pag	Be (25. Was case referred to medica examiner?						of Death (0	Check only one,			
	Physicien: rthis certificaral director, I	P	1 Yes 2 No	Hospital: 1 ☐ Inpati 28a. Date of Inj		ER/Outpatier	IL 3 DOM			5 Residen			/)
u Q	ding After fune	tion	27. Manner of Death 1 Natural 5 Pendir		ay Year)	28b. Time of Injury	Wo	ork? ⊡Yes 2.∐N		d. Describe how	injury occurred	'	
Division of	= 00 >	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of In	njury - At ho	me, farm, str	eet, factory, office					or Rura	l Route Number,
2	after after I Dire	Certification:	4 Homicide	building, e	tc. (Specify)				City or Town,	State)		
	ospita hours unere ly fille		29a. Certifier 1 Certifyin (Check only 2 Medical	ng Physician: To the best	t of my know	vledge, death	occurred at the t	time, date and	d place, and	d due to the cau	se(s) and mann	er as st	ated.
	To the Hospital or At within 24 hours after d To the Funerel Direct completely filled in by	Medical	one)	and manner s	tated.	on and or in							
	To To con	Σ	29b. Signature and fitte of certifie				29c. Licen	ise number	2 1	7 290	I. Date signed (Month,	Day, rear)
			00.11	1111	donth /!	23a) (T	Brint)	4 1 1	//	4	114/	Special and	J
	10		30. Name and address of person	MD 310 HC	Death (Item) RA	Pence	Frale	vict	\sim	2010	75	
	Sta	te	31. Date filed (Month, Day, Year,		tras Signat	ure	1.0					0	
	Registr	ar	JUN	1 2 9 2005	Box	, 15.	gove						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** June 25. Anna Carlson 2005 08:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Corsica Hills Nursing Home Centreville Queen Anne's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🕅 F 220-05-1915 December 13, 1919 85 Director ΜĎ Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exam act must be tredified at 1 ☐ Yes 2 ☐ No Director MD Queen Anne's Church Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 106 Main Street 21623 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after ☐Yes 2X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7. In and Mental Hygiene. 7 is marked other than "no Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Food Industry 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Cahall Julie Chance ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an item 27 is Karen Carlson/daughter 3900 Green Castle Ridge #22, Burtonsville, MD 20866 20a. Method of Disposition
1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages nent of I ō permit. Page Department of Important: If any injury or once. Chesterfield Cemetery July 2,2005 Centreville ^¹ 4 □Donation 5 □ Other (Specify) P.A. Fellows, Helfenbein & Newnam Funeral Home, P.A. 408 South Liberty Street, Centreville, MD 21617 21. Signature of Funeral Service Licensee 1annos 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final A) Theiners demento Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a contequence of): Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician hed for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) 4□Pregnant at time of death detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Hyperlip Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Drillatio certificate has autopsy 1 ☐ Yes 2 No 2 No Division of Vital Hospital or Attending Phyaician: 24 hours after death. director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes Ž No AS Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I †Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) icai 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 27/05 MD f person who completed cause of death (Item 23a) (Type, Print) 30. Name and address FREDERICK DELBOY, M.D., 6602 CHURCH HILL ROAD, STE 200, CHESTERTOWN, MD 21620 2005 Registrary Signature State 9 Registrar

			For State Registrar	State of Mar	•	artment of H		ınd Me		ene 3. No.2 0 (05 230	169
	Physicia	an	Decedent's Name (First, Middle, Last)					-	2. Date of Death Month	Day	3. Time of	
	/Medic	ai	Lois Roy Callaway 4a. Facility Name (If not institution, give si	troot and number)		4b. City, Town, or	Location of		June	22, 20 4c. County	005 12:2	2 p ^м
	Examin	er	971 Ridgeway Drive				polis	i Doaiii		,	Anne Arund	el
	Funeral Director		5. Social Security Number 005-20-0749 6. Sex		ln yrs. last birthday 80 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day,) May 29,	^(ear) 1925	9. Birthplace (State of Country)	or Foreign
	w w		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or t	ocation					10d. Inside C	ity Limits
	Maryla e-f sho	tor	MD Anne Ar		polis			1 ☐ Yes 2 🛣 No				
	or 28	Dire	10e. Street and Number			10f. Zip Code					hat Country?	
	sath v	eral	971 Ridgeway Drive	2. Was Decedent Eve	orio II S 13		401	in? (Speci	ity Ves or No-	14 Bace	USA - American Indian.	
396	72 hours after death with the Maryland Insturel', or ltems 23a or 28e-f show Vical Exam increust be invitted at	by Funeral Director	1 Never Married 2 Marriad 3 SWidowed 4 Divorced	Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Give Year or Dates:	51 11 0.5.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☒No		, Puerto Ri	ican, etc.)		k, White, etc.	
2-0	72 hor	eted	15. Decedent's Educ (Specify only highest grade		16a. Dec	edent's Usual Occupa	ation during most	of working	11	6b. Kind of Bu	siness/Industry	
121	within ane. then "	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 4 (Give kind of work done during most of working life. DO NOT use retired) Secretary						Administration			
d 2	illed Hygie other	Be Co	17. Father's Name (First, Middle, Last)		1	Doorocar		r's Name (First, Middle, Ma			
Maryland 21215-0036	ould be Mental wrked	To B	Louis Roy					Rust				
	s 1 and 2 sh if Health and item 27 is rr other treur		19a. Informant's Name/Relationship (Type Deborah Callaway/			ling Address (<i>Street a</i> 71 Ridgewa					21401	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or flems 23a or 28e-f show appring to other treumetic event, the Marical Examination at the page.		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State		osition (Name of ematory or other plac rematory	:ө)	June 20	24,		City or Town, State	
Balti	permit. Departm Importe any inju		21. Signature of Foheral Service License	9//	Ĕ 4	2. Name and Address Sarranco & 95 Gov. R	s of Facility Sons itchie	P.A e Hwy	. Sever	na Parl na Parl	k Funeral 1 k, MD 211	Home 46
Г			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	. —	CVA						3 days	
ŀ	Examiner				consequence of):							
-	Sit ad	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Figure 1)		consequence of):							
	certificate be executed ding physician and use as the burial-transit	Examlne	that initiated events resulting in death) Last Due to (or as a consequence of):									
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9	ertifica ling ph		IF FEMALE:	De Muse sutcome of								
O. Box	death e atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ Mo 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)				23d. Dati Mor	e of delivery hth Day '	Year
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of \	Phys this al dii	2	1 Yes 2 No	ospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpation		4 1401	-	s 5 X Residen			
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	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	edical C		ician: To the best of eler: On the basis of elerand manner state	xamination and/or i						nner as stated. and due to the cause(s	;)
)	To the within to the comp	Me	29b. Signeture and title of certifor	2	enta	29c. License	e number	438	290	d. Date signed	(Month, Day, Year) LZY 20	25
			30. Name and address of person who con Michael J. LaPen	mpleted cause of deal	th (Item 23a) (Type 445 Defe	nse Hwy.	Annap	∞lis	, MD 2	1401		
	• Sta Registr		31. Date filed (Month, Day, Year)	32. Resistrar's	s Signature	bod						

			State o	of Maryla	_			Mental Hyg	iene	
		State Registrar			Ce	rtificate of l	Death		ag. Ne. U () 5	23070
Physician	,	Decedent's Name (First, Middle, Last)			2. Date of Death Month June 22	Day Year				
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Examine	r	Anne Arundel Medic				Annap		atti	Anne A	
Funeral		5. Social Security Number 6. Sex		7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Birth	0.5	Birthplace (State or Foreign Country)
Director	5	77-40-2942	M 2 X 1 F	74	Yrs.	Months Days	Hours Mi	n. (Month, Day, 3–30–19	931 M	aryland
pur *	-	Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	ocation				10d. Inside City Limits
Maryli f sho	5	Maryland Anne Arun	del		Ann	apolis				1 ☐ Yes 21 No
the ratif	Directo	10e. Street and Number	401			10f. Zip Code		10	0g. Citizen of What	Country?
th with	2	130 Hearne Rd., Ap		21401			USA	USA		
ems er m	Laneral		2. Was Dec	edent Ever in	1 U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
or it	ל ב	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ∐Yes If Yes, G Year or I	2. ZMNo ive	1	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
ture!		15. Decedent's Educa	ition		16a. Dece	dent's Usual Occupa	ation		 16b. Kind of Busine	
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or the	Completed	12th			Boo	kkeeper				of the Navy
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should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland and Manial Hyglene. In arked other then "naturel", or items 23a or 28a-f show umaits event, it a Medical Evernities must be redified at	2	Charles A. 1		us, sr		na Addross (Street	Gla	Clys Sa Rural Route Number,	ample	Zin Codo)
d 2 st d 2 st th and th and treur								ater, MD 2		s, Zip Code)
s 1 and Health Hem 27 other tr	1	David W. Carmack/ Solation Disposition		201		esition (Name of matory or other place			20c. Location - City	or Town, State
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Evertical formatic events.		21. Signature of Funeral Service Ligensee	/	,				George P. and Rd. Ed		neral Home
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xecute and al-tran	Examiner	that initiated events c. resulting in death) Last	Due to	(or as a cons	sequence of):	(0(1×	ET			2 4 4000
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vicien: The lav	Completed							autops perform	ned? death	o completion of cause of ? es 2 \(\subseteq \text{No} \)
ysicien: The lis certificate hadirector, page	D C	25. Was case referred to medical examiner?					26. Place of D	eath (Check only one		
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or Atter frer dea birector or by the	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Plac	e of Injury - A ling, etc. (Spe	t home, farm, st	reet, factory, office		28f. Location (Str. City or Town	reet and Number or , State)	Rural Route Number,
		29a. Certifier (Check only) 29a. Certifier (Check only) 2 Madical Examina	cian: To th	e best of my	knowledge, deat	h occurred at the tin	ne, date and pla	ce, and due to the ca	tuse(s) and manner	as stated.
the H hin 24 the F nplete	Medical	one)	and mai	nner stated.		29c. License			9d. Date signed (Mo	
To with	-	29b. Signature and vitle of certifier				Dan_	35 Y 9	4	6/24/2	2005
		30. Name and address of person who com			Item 23a) (Type,	Print)	1 10	e 1 -	6	
			lsn(6	Registr s Si	AMMe.	The on el	u mi	yeur Co	re	
State Registra	- 48	31. Date filed (Month, Day, Year)	2005		griature &	1 -				

			Please T	ype or Print in	Black In	delible l	nk. Ensure	All Copies	Are Legible	
			For State	State of Marylai	-		f Health and of Death		_	20071
			Registrar 1. Decedent's Name (First, Middle, Last)			uncate	Dealli	2. Date of De		3. Time of Death
	Physici /Medio		LEATITIA	MARIE	CHE	AVERS		Month O 6	Day Year	
	Examir		4a. Facility Name (If not institution, give s	treet and number)	1.141		m, or Location of Dea	nth	4c. County of D	eath .
	Funeral		5. Social Security Number 6. Sex	, ,	last birthday)	If Under 1 Y			th 9 F	Birthplace (State or Foreign
	Director		162 -40 -5345 1 Usual Residence of Decedent	M 2/20 58	Yrs.	Months D	ays Hours Mir	Month, Da	10-46	Country) PA
	yland		10a. State 10b. County	10c. C	ty, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ma 23a or 28a-f show rroust be notified at	Funeral Director	MD WICOM	1100	5	1 L15 E	BURY			1 ☐ Yes 2 TNo
	3a or	Ö	5766 CORK	5-		10f. Zip Co	801		10g. Citizen of What	Gountry?
	r death	Inera		2. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decedent	of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No	14. Race - A Black, W	merican Indian,
36	be filed within 72 hours after death with the Marylan lat Hygiene. Id other than "natural", or Itema 23a or 28a-f show avent, I'ra Madical Exactiner must be notilied at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		□Yes 25	No Specify:	,	Specify:	731 ACK
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121	filed within Hygiene. other than ont, the Me	ompl	Elementary/Secondary (0-12)	College (1-4or 5+)		ONOT USE TO			/ NENS	OF THE WEEK
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altimore,	- I & =		20a. Method of Disposition 1 Burial 2 Cremation 3 R	20b.	Place of Dispo	sition (Name o	f	Date	Oc. Location - City	or Town, State
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g	permit. Depart Import any inj		21. Signature of Funeral Service License	Pound) 9	. Name and A	TSARE	BENNIE	SALISBU	FIH
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consecution)	STO Quence of): DTO	or the mode of the	dying, such as cardia MORRI	ac or respiratory a	rrest,	Approximate Interval Between Orget and Death
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<u>8</u>	w requires that the been signed by the should be detache		Part II. Other significant conditions con	tributing to death but not res	sulting in the ur	derlying cause	given in Part I.			to the cause of death?
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-Chro	The la ate has page 2	Completed						1 Yes	2 No 1 L Y	autopsy findings available o completion of cause of ? es 2 🖾 No
5	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatien	3 DOA	Other	eath <i>(Check only o</i>	one) dence 6 □Other (Sp	necify)
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	(D)		Julies		14T)	<u> U</u> E	101943	52	6/26/0)~
	B		30. Name and address of person who con	noleted cause of death (Iter	KIUE	PAIDE	D2 S	ALISE	uny! 1	MD
	Sta Registr	20	31. Date filed (Month, Day, York) 9.2	32. Restrar's Signa	ature #	parte			('	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Henry Jefferson Cooper, Sr. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 54/15/11/ HICOMICO ININSUIA 19101141 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 MM 2□ F 159-26-3786 73 Yrs. Director 1932 South Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28e-f show treumatic event, the Medical Examirer must be notified at 1 Yes 2X No Director Maryland Wicomico Quantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5440 Sandy Hill Road 21856 Completed by Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Black Specify: 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th transportation driver SEPTA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o Jefferson Cooper Rosalie Cunningham ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Carolyn Cooper/wife 5440 Sandy Hill Road - Quantico, Maryland 21856 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Importent: if it any infury or o once. 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Shelton Hill Cemetery 07/02/2005 Philadelphia, Pennsylvania 21. Signature of Funeral Service License 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ARDS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or minry Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Syndrome Quillaun Barre that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) detached been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably Completed 1 ☐ Yes 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No certificate 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 57952 6/26/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SA/. sbuny Md. 21801 DAS 100E CARROLL ST. BAbulaL JUN 2 9 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical

Examiner

Funeral

Director

To Be Completed by Funeral Director

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician /Medical **Examiner**

Examiner

Please 1	Type or Print in Black	(Indelible Ink. Ensure A	Il Copies Are	Legible.
		epartment of Health and N	-	•
1 - State Registrar		Certificate of Death	Rea. Ma	000 00000
1. Decedent's Name (First, Middle, Last	")		2. Date of Death	the of to entitle 1
Brenda FAY	ie Collick		Month Da	05 0250 M
4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	40	County of Death .
5. Social Security Number 6. Se	x 7. Age (In yrs. last birti	hday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
217-50-4053	The orthogo	rs. Months Days Hours Min.	(Month, Day, Year)	49 N.C.
Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
Md. Wicom	ice Smlis	bury		1 ⊈Yes 2 □ No
10e. Street and Number	N	Of. Zip Code		izen of What Country?
426 Keene	Alve	2/801	Li	1.5,14,
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
15. Decedent's Edu (Specify only highest grad	de completed)	Decedent's Usual Occupation (Give kind of work done during most of work lifeDO NOT use retired)	ing 16b. K	ind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Domestic	de	2 Earl 20 Ding
17. Father's Name (First, Middle, Last)			e (First, Middle, Maiden	Sumame)
Clarence Law		HAZE,	1 Croown	
19a. Informant's Name/Relationship (Ty	ype, Print) 19b.	Mailing Address (Street and Number or Rur Zle Keene Ave S	al Route Number, City of	or Town, State, Zip Code)
20a. Method of Disposition 1	Removal from State	r, crematory or other place)	Date 20c. Lo	ocation - City or Town, State
21. Signature of Funeral Service Licens		22. Name and Adress of Facility LEWIS WEST REV. S	Finery Hor	me 2180/
23a. Part1. Enter the disease, or complete shock or heart failure. List only of	lications that caused the death. Do no	ot enter the mode of dying, such as cardiac		Approximate Interval Between
Immediate Cause (Final disease or condition	Droxic	over lilantel		Onset and Death
resulting in death)	a. Due to (or as a consequence of	0:		Vays
Sequentially list conditions,	h Cay	liguy restel		4 Carry
if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of	f):		
Cause (Disease or injury that initiated events resulting in death) Last	c	20 M 28		Jany
resulting in death) cast	Due to (or as a consequence o	f):		,
	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco t	use contribute to the cause of death?
	End. Dro	Jewl Jarly		□ No 3 □ Probably 4 □Unknown
	,		24a. Was an	24b. Were autopsy findings available
			autopsy performed? 1 Yes 2 No	prior to completion of cause of death?
25. Was case referred to medical examiner?	Uponital.		h (Check only one)	
1 ☐ Yes 2 🕱 No	Hospital: 1 Impatient 2 ER/Out		me 5 Residence	
27. Marrier of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Ti	me of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inju	y occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,
29a. Certifier (Check only one) Certifying Phy 2 ☐ Medical Exami	rsician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	death occurred at the time, date and place, /or investigation, in my opinion, death occur	and due to the cause(s) red at the time, date and	and manner as stated. d place, and due to the cause(s)

Physician/Medical 9 Unkn Part II. Other si Be Completed by 25. Was case reasoning? Certification: To 1 Yes 27. Marrier of D 2 Accide 3 Suicide

29b. Signature and title of certifier

Medical

State Registrar 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month 30N 3") 0 2005

c Tan w

26			For		Sta	ate of N	<i>M</i> arylar						lental Hy	giene	J	
M,			1 - Stete Registrar					C	ertifica	te of l	Death			Reg. No.	005	23074
7	Physici		1. Decedent's Nam		Mae Mae	(Colema	n				ļ	2. Date of De Month	eath Day	Year	3. Time of Death
4	/Medic Examin		4a Facility Name (-	411	4b. City	, Town, or	r Location	of Death	sumo	4c.	County of Death	3150 M
4	LAGITII		Peninga	ula Re	Mon	WMP	dicas	2 Center	1 80	ulist	oun				DICOM	
6	Funeral		5. Social Security N		6. Sex 1 ☐ M 2			last birthda	y) If Unde	Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Di 9/24/1	rth ay, Year)	Q Righ	plane (State or English
n	Director		239-44-2.			2124.1	73	Yrs.					9/24/1	931	North	n Carolina
13	rland ow		10a. State	10b. County			10c. Ci	ty, Town or	Location							10d. Inside City Limits
#	the Marylar 28a-f show	tor	Maryland	Wico	omico			Salis	bury							1. Yes 2 □ No
N	or 28	Oire	10e. Street and Nu			_			10f. Z	ip Code				10g. Citiz	zen of What Cou	intry?
N	within 72 hours atter death with the Maryland with in 72 hours atter death with the Maryland ene. Then "teturel", or items 23e or 28a-f show item "teturel", or items 23e or 28a-f show item is well be a rediffical at	by Funeral Director	419 Dove	er St.						21804					USA	14
5	ter de Items	nne	11. Marital Status	ried 2 Marrie	Ai	/as Deceder med Force: Yes 2	s?	J.S. 13	3. Was Dece If Yes, sp	edent of H ecify Cuba	ispanic Ori In, Mexicar	igin? (Spe n, Puerto	cify Yes or No Rican, etc.)	0- 1	 Race - Ameri Black, White 	
7 8	urs af	by F	3X Widowed	_	i If	Yes, Give ear or Dates			1 🗆 Yes	2 X No	Specify:				Specify:	white
> 2	72 ho	Completed	(Sner	15. Decedent's	s Education	n/eted)		16a. Dec	edent's Usi	ual Occupa	ation	t of worki	na	16b. Kir	nd of Business/Ir	ndustry
4	ithin dithin	nple	Elementary/Seco		1	oilege (1-4o	or 5+)		ve kind of w . DO NOT		dinig mos	N OF WORK	ng .			
~	liled w Hygien Ther ti	Co	10 17. Father's Name	(First Middle I	ast)			pry	Clea	ner	19 Moths	arte Namo	(First, Middle		Cleani	ng
a Colema	d be d be d shall lead o	To Be	Ned Parl										ie Bosw		Surrame)	
3	shoul mid Mind Mind Mind Mind Mind Mind Mind Mi	۲	19a. Informant's N	ame/Relationshi	р (Туре, Р	rint)		19b. Ma	iling Addres	s (Street a					Town, State, Zi	p Code)
	and 2 aatth a aatth a r 27 is		Rodney I	E. Colen	nan/sc	on		31	517 H	itch	Pond	Rd.,	Laure	1, DE	E 19956	
7	ditiliore, mit. Pages 1 a partment of Her portent: if item y injury or othe		20a. Method of Dis	position Cremation	3 □Remov	al from Stat	20b. F	Place of Discemetery, controls	position (Na ematory or	me of other plac	e)	_	ate	20c. Loc	ation - City or T	own, State
7 .	Pag tment tent:		° 4 □ Donation	5 Other (Sp	ecify)		s Sp	Gar	dens			7/1/			oron, MD	
0, 0	portitione; Interpretable ALALISTOOSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martial Hygienia. If item 27 is marked other then "naturel", or items 23e or 28e-1 show any injury or other treumetic event, the Martial Examinational beneatible 1 at once.		Scripture of Fu	uneral Service Li	icensee				HOI1	nd Addres	s of Facilit Funer	al H	ome Pro	ofess	ional A	ssociation
٧.			23a. Part1. Enter t	the disease, or c	omplication	ns that caus	ed the deat	>	_501_8	Snow	HITT	Rd.,	Salis	bury,	MD 218	04 Approximate
	Physician		shock, or hea Immediate Cause	art failure. List o (Final	nly one cau	use on each	line.						,	,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a	Due to (or a			ceph	(0)	um	7—				
	Examiner		Sequentially list co	anditions	b											
	ad sit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying		Due to (or a	as a consec	quence of):								
	xecute and il-tran	хаш	that initiated events resulting in death)	S	c	Due to (or a	as a consec	uence of):								
0220	ate be executed the burial-transit	dicai E				,		, , .								
4	g physias the	edic			u											
9	es that the death certific igned by the attending be be detached for use as	by Physician/Me	IF FEMALE: 23b. Was deceden			yes, outcom □Live birth			I □Ectopic p	recnancy				2	3d. Date of deliv	
	e dear	sicia	in the past 12 1 Tyes 2 (9 Unknown	□No	4[□Pregnant □Unknown	at time of o		Other (s						Month	Day Year
0	hat th ed by detach	Phy	Part II. Other signif		s contribut	ting to death	but not res	ulting in the	underlying	cause dive	an in Part I		23e Did t	obacco us	se contribute to t	he cause of death?
Od shrond lettive or observed	uires t	d by	Tarris outer organi			ing to double	Dat Hot 100	and and	undonying	ouuso gire	arrier arci.		1	Yes 2		
Š	w require been si should b	iete										-	24a. Was	an	24b. Were auto	ppsy findings available
ū	The fav te has age 2	Completed											auto	psy prmed?	prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
÷	ien: 'ien: 'trifica	BeC	25. Was case refer	rred to medical							26. Place	of Death	(Check only o	2 🛂 🗖 o	1 1 1 1 1 1 1	2 140
>	hysic his ce	To	examiner? 1 Tes 2	HV0	Hospita	1 L91npa		ER/Outpati		OA Othe	er: 4 □ Nu	rsing Hon	ne 5 Resi	dence 6	Other (Special	fy)
2	ing P	on:	27. Manner of Deat	5 Pending		a. Date of In (Month, D	ijury Day Year)	28b. Time Injury		28c. Injury Work	at	2	8d. Describe			
	ttend death death stor: /	icat	2 Accident 3 Suicide	investiga 6 🗌 Could no	* ho	e Place of I	niuny - At h	ome form	M facto		Yes 2□I	_	98f Location /	Street and	Number or Pur	al Route Number,
2	after Dire	Certification:	4 Homicide	determin	ied 25	e. Place of I building,	etc. (Specif	(y)	stroot, racio	y, omos			City or To	wn, State)	Transcor or Trans	ar route repriser,
	Hospitel or Attending Physicien: The law requires that the death certific 24 hours after death. 24 hours after death. 26 hours after death. 27 hours after death. 28 hours after death. 29 hours after this certificate has been signed by the attending pelly filled in by the tuneral director, page 2 should be detached for use as		29a. Certifier	1 Certifying	Physician	: To the bes	st of my kno	wiedge, de	ath occurred	1 at the tim	e, date an	d place, a	and due to the	cause(s) a	and manner as s	stated.
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only one)		aminer: C	on the basis and manner	or examina stated.	uion and/or				th occurre	at the time,		place, and due t	
	ToT	2	29b. Signature and	title of certifier	the	11 &				c. License				29d. Date	signed (Month,	
	an			12	gyv					15 4	807		a - Branch Control	6/	28/20	
	1/2		So. Name and addr							5.	a1156	414	mo	•	•	
	Sta	te	31. Date filed (Mon	ith, Day, Year)		32. Pais	strar's Signa	arnoll ature				1			<u></u>	
	Registr	ar 🔭		JUN3 (2005	10-	See .	K	Angel.	,						

433	,	•	1 - For Stete Registrar	State of Ma		artment of F		Mental Hygie	ene No.200c	000
	Physici	an	Decedent's Name (First, Middle, CHARLES	~	CAMPBELL			2. Date of Death Month	Day Year	Time of Defith
	/Medio		4a. Fecility Name (If not institution,			4b. City, Town, o	r Location of De	June 27	7, 2005 4c. County of Death	13:49 A ™
			Rt. 13 and Cent		- No see look binds	Salisb		re la D.A. (Bish	Wicomico	
	Funeral Director		5. Social Security Number 218–86–3808	6. Sex 7. Age 1	e (In yrs. last birthday 39 Yrs.	Months Days	Hours Mi			place (State or Foreign intry) MD
	and and		Usuel Residence of Decedent 10a. State 10b. County WICC		10c. City, Town or L	ocation				10d. Inside City Limits
	a-fsho	ctor	MD WICO	OMICO	10c. City, Town or L SALIS	SBURY				¥ Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. Itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examiner meatice notified at	Funeral Director	10e. Street and Number 419 ELIZABETH	ST.		10f. Zip Code 21804		10g	Citizen of What Cou USA	intry?
	itams itams	uner	11. Marital Status 1X Never Married 2 Marrie	12. Was Decedent Armed Forces?		Was Decedent of H If Yes, specify Cuba	fispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White	
21215-0036	ours af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes X No	Specify:		Specify: WI	IITE
15-0	n 72 ha	Completed	15. Decedent' (Specify only highest		(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of w	vorking 16	b. Kind of Business/I	ndustry
212	filed within Hygiene. other then "	Omp	Elementary/Secondary (0-12)	College (1-4or 5	1+)	OCK PERSON	*	:	RETAIL	
Maryland	ould be filed Mental Hygis karkad othar katic evant, I	To Be (17. Father's Name (First, Middle, L CHARLES H.	ast) CAMPBELL				ame (First, Middle, Ma A ONLEY	iden Sumame)	
	1 and 2 should Health and Men am 27 is marka thar traumatic		19a. Informant's Name/Relationsh BRENDA HARRIS	Rural Route Number, C ALISBURY,	City or Town, State, Zi	o Code)				
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from State		matory`or other plac			c. Location - City or T	
ıltim			' 4 ☐ Donation 5 ☐ Other (Sp 21. 3 gnature > Funeral Service L			2. Name and Addre			DELMAR, DE	
ñ	permit. Departr importa any inji		Densi,	Skell		2. Name and Addre BOUNDS FU 05 EAST M		OME EET, SALIS	BURY, MD 2	1804
	Physician /Medical Examiner		23a. Part1. Enter the disease, or o shock, or heart failure. List o immediate Cause (Final disease or condition resulting in death)	omplications that caused nly one cause on each lir	a consequence of):	iter the mode of dyin	ng, such as cardi	ac or respiratory arrest		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-fransit	cal Examiner	Sequentially list conditions, if any, leading to innerliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of):					
.O. Box 68	death certific e attending p ed for use as f	Physiclan/Medlcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy	/		23d. Date of deliv	ery Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant condition	s contributing to death be	ut not resulting in the t	underlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to	he cause of death?
	ian: The law requires that the rifficate has been signed by th ctor, page 2 should be detach	Completed						24a. Was an autopsy performed	d? prior to co	opsy findings available impletion of cause of
Vital	5 6 8 E	o Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital:	nt 2 ER/Outpatie	nt 3□ DOA Oth	er	eath (Check only one) Home 5 🗆 Residence	e e Other (Speci	wat scene
ion of	nding Physith. Ith. : After this e funeral di	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate	28a. Date of Injur (Month, Day	ry 28b. Time o	of 28c. Injury	y at	28d. Describe how Declared by Fruc	nding bil	co, struct
Division	To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be age Place of Inju	urv - At home, farm, st			28f. Location (Stree City or Town, S	et and Number or Run State) NB US I	2+ 13 and
	Hospit 14 hour Funara 19ly fille	edical C	(Check only 2 Medical E	Physicien: To the best oxaminer: On the basis of	of my knowledge, deal examination and/or in	th occurred at the tin	ne, date and pla pinion, death oc	ce, and due to the caus	e(s) and manner as s	tated.
	To the Hospital or Al within 24 hours after of To the Funaral Dirac completely filled in by	Med	29b. Signature and title of certifier	the rennem bine	merc.	29c. Licens		Jun	Date signed (Month, e 27, 2005	Day, Year)
•	3de		30. Name and address of person w	no an incled cause of de	eath (item 23a) (Type	Print) 111 Pen	n Stree	t Baltimor	ce, Maryla	nd 21201
	Sta Registr		31. Date filed (Month, Day, Year)	0 2005 32. Resistra	ar's Signature	-			, - mil y 10	TO STAGE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 29,2005 Ruth Simmons Costenbader 9:15 am /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Pinetree Assisted Living LaPlata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, August 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 14,1922 West Va. Months 1 ☐ M 2 🔯 F 228-14-0979 Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Eran iner must be notified at M☐Yes 2☐No Directo Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a 3955 Stony Point Place 20640 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after in and Mental Hygiene. is marked other than "natural", or Ital 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ð Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Her Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arlie Simmons Propst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20640

Thdian Head, Md. 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any njury or other traum Carl W. Costenbader Husband 3955 Stony Point Place, Indian Head, 20b. Place of Disposition (Name of cemetery, crematory or other place) Tune 30, 2005

Metropolitan Funeral Service Alexandria, Va. 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Williams Funeral Home, P.A. 4270 HAwthorne Rd., Indian Head, Md. M00668 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help t failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final alzheimers Physician disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Pherel vascul Sequentially list conditions, tary leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bis a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit VICE Due or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) by the 9 Unknown 9 Unknown signed by the Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2D No certificate 1 ☐ Yes o the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a

To tha Funaral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) VA 0101236885 Perron MAJ VIDEMC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20762 Andrew ARB MO V2d 32. Regitrar's Signature 31. Date filed (Month, Day, Year) State JUN 3 0 2005 Registrar

			1 - For State Registrar	State of Maryl		artment <i>rtificate</i>			d Mental	Hygier		O 17	
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Frances	J. C	Cox				2. Date June		∠U 2005	Year	2 тіть фраф 7 9:00а м
	Examin		4a. Facility Name (If not institution, give s 10009 Fall Rai				own, or Lo	ocation of D	eath		4c. County HOW	of Death ard	
	Funeral Director		5/0-10-9393	M 213xF 7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Months		Hours N	din. (Mont	of Birth h, Day, Yea 16,1	918	Coun	lace (State or Foreign try) nton, N.J.
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Howard	10c	. City, Town or Lo Laur							1	0d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show trust be notified at	Director	10e. Street and Number 10009 Fall Rair	Drive		10f. Zip C	207	23	-	10g. (Citize <i>n</i> of W		try?
920	be filed within 72 hours after death with the Marylan Ital Hygliene. d other than "natural", or items 23a or 28a-1 show event, the Midical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decede If Yes, specif		anic Origin' Mexican, Pi	? (Specify Yes uerto Rican, etc	or No-	14. Race Blac	e - Americ k, White, Whi	etc.
21215-0030	d within 72 ho jiene. ir than "naturi ine Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done dur retired)	on ing most of	working	16b.	Kind of Bu		,
land	uld be filed Mental Hygis Irked other Itic event, II	To Be C	17. Father's Name (First, Middle, Last) Alex Hier				18		Name (First, M Le Haje		en Sumam	e)	
, mar)	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evense.		19a. Informant's Name/Relationship (Ty). Charles T.Cox/I		1	ng Address (9 Fal			r Rural Route N Orive				^{Code)} 20723
baitimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1		b. Place of Dispo cemetery, cre Ft.Li	matory or oth	er place)	n. 6/	Date 29/05		entw		
pall	permit. Departi Import any inj		21. Signature of Juneral Service License	Mi	<u> </u>	HILIF 241 C	Address Colu	ŔĪŴÄI mbia	DI FUI Blvd.	NERAI Silve	SEF er Sp	VIC	E,P.A. g,Md20910
8/60,	Physician /Medical Examiner authorisis	dical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Sepsis Due to (or as a con	sequence of):								Interval Between Onset and Death
O. Box 6	death certil e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ac. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic prec □ Other (spec					23d. Date Mon	of deliver	y Day Year
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al Records	The law ate has b page 2 s	Completed							_	Was an autopsy performed?	d	/ere autoprior to comeath?	sy findings available apletion of cause of 2 No
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 ER/Outpatier	nt 3□ DOA	Other		Death (Check o		6 🗆 🗆	. (0	
lon or	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o		c. Injury at Work?	4 INUISIII	28d. Desc		jury occurre		1
UIVISION	tat or Atte s after dez al Director ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, streecify)	reet, factory,	office			on (Street or Town, Sta		r or Rural	Route Number,
	he Hospi in 24 hour he Funer pletely fill	edical	(Check only 2 Medical Examinona)	icien: To the best of my er: On the basis of exan and manner stated.	knowledge, deat nination and/or in	h occurred at vestigation, in	the time, n my opini	date and pl ion, death o	ace, and due to ccurred at the t	the cause me, date a	(s) and mar nd place, a	ner as sta nd due to	ited. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c.	License n		0		ate signed		
	16		30. Name and address of person who co		(Item 23a) (Type, 00 Gall)5370 #210	Bowi		une		005
	Sta		Dr.Raj Chawla 31. Date filed (Month, Day, Year)	22. Registrar's S			. 0.	π 2 1 0	DOMI	, PIC	201		
	Registi	ar	JUN 29 2005	Here I	a lake								

			_ State	State of Maryla		artment of F		l Mental Hy	000	F 00070
			Registrar 1. Decedent's Name (First, Middle, Last)		00,	inicate of	Dealit	2. Date of D		3. Time of Death
	Physici /Medio		Johnny H. Ch					June	Day 24 20	05 7:45pm ^M
	Examin	er	4a. Facility Name (If not institution, give si			4b. City, Town, o		ath	4c. County of	
	Funeral		Montgomery Ge 5. Social Security Number 6. Sex		tal rs. last birthday)	If Under 1 Year	Olney If Under 24 H			gomery B. Birthplace (State or Foreign
	Director		111-40-3643	M 2□ F 81	Yrs.	Months Days	Hours Mi	n. (Month, Di	ay, Year) 1923	Birthplace (State or Foreign Country) China
	land		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Mary B-f sho	tor	MD Montgome	rv		Rockville	2			1 ☐ Yes 2 🛣 No
	or 28	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	eath w	Funeral Director	13001 Payson Street	2. Was Decedent Ever in	11.6 12.1	Man Deceded of L	2085		United S	
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, It is Macical Examiner must be motified at	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📆 No	!	Vas Decedent of H		erto Rican, etc.)		American Indian, White, etc.
003	ural', c	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:		Specify:	Asian
15	in 72 h "natu	Completed	15. Decedent's Educi (Specify only highest grade	completed)	16a. Deced (Give	lent's Usual Occup kind of work done DO NOT use retired	ation during most of w	rorking	16b. Kind of Busi	ness/Industry
212	d with giane.	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		ner	-/		Restaur	ant
g	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	, Maiden Sumame)	
Maryland 21215-0036	d Men marka matic	으	Unavailable Chiang 19a. Informant's Name/Relationship (Typ		405-14-15				available	
	nd 2 s lith an 27 ls i r traui		Cheng-Mo Chiang / S	*					er, City or Town, St urch, Vir	ginia 22043
Baltimore,	of Head		20a. Method of Disposition	206	Place of Disno		ral la	Date	20c. Location - Ci	
<u>E</u>	tment of land: If its		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		ate of C	neaven emetery	Ju 2	ne 28 005		pring, MD
Ba	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 Is marked any injury or other traumatic enong.		21. Signature of Funeral Service Licensee			. Name and Addre: eer Park		DeVol F Gaithers	uneral Ho burg, MD	me, 10 East 20877
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the de cause on each line.	ath. Do not ente	er the mode of dyin	g, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Pneumoni	a				Onset and Death
i.	Examiner			Due to (or as a cons		vascular	Accider	a t		
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0	rtificat ng phy as the	a)	ISSENALE:							
X P P	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of preg 1 Live birth 2 Pe	tal death 3	Ectopic pregnancy			23d. Date of	,
	the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	death 5	Other (specify)			Nontr	oay real
ران ح	is that the	by Pr	Part II. Other significant conditions conti	ributing to death but not re	sulting in the ur	derlying cause give	en in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?
Kecords,	w requires that been signed to should be deta							1 🗆 '	Yes 2□No 3[☐ Probably 4 Munknown
Š	e law r has be	ompieted						24a. Was	osv prio	re autopsy findings available r to completion of cause of
	That are pag	e Col	25. Was case referred to medical					perfo		tn? Yes 2□ No
<u> </u>		0 0	examiner?	spital:	☐ ER/Outpatient	3 DOA Othe	000	eath Check only of	one) dence 6 ⊡Other((Specify)
n or	ng Phys fter this ineral di	on: T	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at at		now injury occurred	op cony)
UNISION	ttendi death. stor: A the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home form stee		Yes 2□No	296 Lagation /	Street and Mumber	Over 1 Day to March 1
2	tal or A rs after al Direct ed in by	Certification:	4 Homicide determined	building, etc. (Spec	cify)	et, ractory, office		City or Tov		or Rural Route Number,
	To the Hospital or Attending Ph A within 24 brous alter death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my kr er: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the time estigation, in my op	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	withii To th	M	29b. Signature and title of certifier		Aland	29c. License	number		29d. Date signed (A	Nonth, Day, Year)
	10		· Wilkem	n J.	IVITA		D45285		June 2	27, 2005
			30. Name and address of person who com			, ,	R1 to A to	Cil	Carina 1	m 20001
	Sta		Wilkinson J. 31. Date filed (Month, Day, Year)	3. Registrar's Sign	nature	W.	DIVU W.,	PITAGL	shirig.	m 7030T
	Registra	ar	JUN 29 2005	MANUE L	To payment					

			riease	, ,	Marylan						•	aiene	-09.0.		
		1	For State Registrar	Otato o.		•	tificate				•	Reg. No	200	5	23070
	Dharini		1. Decedent's Name (First, Middle, L								2. Date of De. Month		Y	ear	3. Time of Death
ı	Physicia /Medic		GEORGE JAMES	CARDY							June	Day 27	20	005	1:00 A ^M
	Examin	er	4a. Facility Name (If not institution, gi		iber)			Town, or ckvi	Location o	f Death		1 .	County of I		2 77
			Casey House - 5. Social Security Number 6.		7. Age (In yrs. I	ast birthday)	If Under		If Under:	24 Hrs.	8. Date of Bir (Month, Da		Monte		ace (State or Foreign try)
	Funeral Director		367.20.1249	1፟M 2□F	79	Yrs.	Months	Days	Hours	Min.	Aug. 1	6, 1	925	Mic	higan
<u></u>	p ,		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	veation							10	Od. Inside City Limits
	shov	ō													1X Yes 2 □ No
	28e-f	Director	Maryland Montgo	пегу		ilver	10f. Zip					10g. Citiz	zen of Wha	at Coun	try?
	3e or	i Di	914 Brick Manor	Circle			20	0905				U.	S.A.		
	ems a	by Funerai	11. Marital Status	12. Was Dece Armed For	dent Ever in U.	S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.))- 1	14. Race - Black,		
36	s afte	y Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes If Yes, Giv	2□No e WW II ates:WW II		1 ☐ Yes		Specify:				Specify: V	Vhit	e
8	filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or Hems 23e or 28e-f show ent, the Medical Evain act must be notified at	edt	15. Decedent's	Education	1103.	16a Dece	dent's Usua	al Occupa	ation			16b. Kir	nd of Busin	ess/Ind	lustry
215	hin 72 9.	piet	(Specify only highest g	rade completed) College (1	-4or 5+)		kind of wo DO NOT us				ng				
21	ed wit	Completed		5+ Ye	ars	Sto	ck Bro	oker,			/F: A F-1-11-		nance	•	
Maryland 21215-0036	be filk	Be	17. Father's Name (First, Middle, Las Thomas G. Car							rs Name enia	(First, Middle, Altin		Sumame)		
7	houid d Mer marke matic	To	19a. Informant's Name/Relationship		<u> </u>	19b. Maili	na Address	(Street a			I Route Number		Town, Sta	ıte, Zip	Code)
Z	Ith an 27 is i		Frank G. Cardy/								, Silve				
re,	Hea item		20a. Method of Disposition		0	lace of Dispo	osition (Nam	ne of ther plac	Θ)	С	ate	20c. Loc	cation - Cit	y or To	wn, State
E	Page nent o		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec		state	dar Hi	11 Ce	mete	ry (/2005				ryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment if item 27 is marked other then 'neturel', or items 23e or 28e-f show eny injury or other treumatic event, it is Medical Examination must be notified at once.		21. Signature of Funeral Service Lic	ensee	ti	H 1	2. Name an INES- 1800	d Addres RINA New	s of Facilit LDI H Hamps	UNER shire	AL HOM	E, IN Silve	NC. er Sp	ring	g, MD 20904
			23a. Part1. Enter the dispare, or co shock, or hear failure. List on	mplications that c	aused the death	n. Do not en	ter the mod	e of dyin	g, such as	cardiac c	r respiratory a	rrest,			Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):		onav	,					,	Years
Ь	HILES	e.	Sequentially list conditions, if any, leading to immediate		ic Rena		.11101	ency						+	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C											
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89 x	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, out	come of pregna	incy						2	23d. Date of	of delive	rv
Вох	atten atten	cian	23b. Was decedent pregnant in the past 12 months? 1 \sum Yes 2 \sum No	4□Pregn	irth 2 ☐ Feta ant at time of d		⊒Ectopic pi ⊒ Other (sp						Month		Day Year
o.	t the d by the ached	hysi	9 Unknown	9□ Unkno	own										
s, D	res tha igned be del	by P	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	inderlyi <i>n</i> g o	ause give	en in Part I						e cause of death?
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Sec.	e law has b je 2 sh	ompleted									24a. Was auto perfo		pric	re autop or to con oth?	psy findings available inpletion of cause of
alF	Th ate pag	O							00 81	- (D 1)	1 ☐ Yes	2 🖾 No	1 🗆	Yes	2□ No
Vital		o Be	25. Was case referred to medical examiner?	Hospital:	npatient 2	ER/Outpatie	nt 3□ D0	Oth	00		n <i>(Check only o</i> me 5 ☐ Resi		Other	(Specify	, Hospice
10		-	27. Manner of Death	28a. Date		28b. Time o		28c. Injun			28d. Describe				
ior	Attending I ir death. ector: After by the funer	atio	1 XNatural 5 Pending 2 Accident investigat	on			М	1 🗆	Yes 2						
Division	of or Attending after death. I Director: After de in by the fur	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 200. Flace	of Injury - At he ng, etc. (Specif	ome, famn, st y)	reet, factor	y, office			28f. Location (City or To			or Hura	l Route Number,
	Hospitel 24 hours a Funerel E tely filled i		29a. Certifier 1 🔀 Certifying	Physician: To the	best of my kno	wledge, dea	th occurred	at the tin	ne. date ar	nd place.	and due to the	cause(s)	and mann	er as st	ated.
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medicai		aminer: On the b											
	To the within 2 To the complet	Me	29b. Signature and title of certifier			-	29	c. Licens	e number						Day, Year)
	ID		I Chiki y	re			D	-424	52			June	27,	2005	· · · · · · · · · · · · · · · · · · ·
			30. Name and address of person where the contract of the contr	o completed caus	e of death (Item	n 23a) (Type Muncas	Print)	1111	Road	, Roc	kville	, Mai	rylan	d 20	0850
	Sta		31. Date filed (Month, Day, Year)	32 B	egistrar's Signa	ature									
	Regist	al	JUN 29 20	UJ March	41 15	Para	2.00								

			1 For State	State o	of Maryland		artment of rtificate o			-		0.5	
			Registrar 1. Decedent's Name (First, Middle	a Last)			uncate o	Deau		2. Date of De	Reg. No	1115	23080
	Physic		ROBERT		-		_			Month	Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution,	WILLIS give street and nu		ODSOI	4b. City, Town	. or Location	of Death	JULY 7	2005	ty of Death	12:09P M
1	LXdiiii	ici	FREDERICK MEMOR				FREDERI		01 50001				
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Year	ar If Unde	r 24 Hrs.	8. Date of Birt	h	ERICK 9. Birthr	place (State or Foreign
	Director		195-30-3631	1₩ 2□F	66	Yrs.	Months Day	/s Hours	Min.	June 2,	1939	COU	nsylvania
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						04 1-14 05 11
	Maryl 1 sho	5		erick								'	0d. Inside City Limits 1 √ Yes 2 No
	the 128a-	rect	10e. Street and Number	ELICK	Mye	ersvi	10f. Zip Code				10g. Citizen of	What Cour	**
	72 hours after death with the Maryland Instural', or Items 23a or 28a-1 show occil Examinat Trust or notified at	Funeral Director	10230 Meadowrid	ge Drive			217				US		itry !
	death	Jera	11. Marital Status	12. Was Dec	edent Ever in U.S.	13. \			rigin? (Sp	ecify Yes or No- Rican, etc.)		ce - Americ	an Indian.
9	after or ite	Ē	1 ☐ Never Married 2☐XMarrie		2 🔼 No					Rican, etc.)		ack, White,	etc.
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5-	be filed within 72 hours after death with the Marylan nia! Hygiene. So do ther than "natural", or liems 23a or 28a-1 show event, the Moderal Exument must be notified at	Completed	15. Decedent' (Specify only highest	's Education t grade completed)	1	6a. Deced	lent's Usual Occ kind of work dor DO NOT use reti	upation e during mo	st of work	ing	16b. Kind of I	Business/Inc	dustry
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ary	s 1 and 2 should t Health and Men item 27 is marke othar traumatic	-	19a. Informant's Name/Relationsh	iip (Type, Print)	er or Run	al Route Number	r. City or Towr	. State. Zip	Code)				
	12 E d		Elda M. Dodson/	wife						e, Myer			
Baltimore,			20a. Method of Disposition	- 77		e of Dispos	sition (Name of natory or other p	lace)		Date	20c. Location	- City or To	wn, State
im	permit. Pages Department of I Important: If Its any injury or of		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	-		- 1	Ju1y	11, 05	Frede	rick.	Maryland
alt	permit. Pag Department Important: I any injury o		21. Signature of Fineral Service L	icens e			. Name and Add				Main		
-	90789		1ag 7.4	with			icketts				rsvill	e, MD	21773
			23a. Part 1. Enter the disease, or a shock, or heart failure. List of	complications that conly one cause on e	caused the death. C	Do not ente	er the mode of d	ying, such as	cardiac o	or respiratory arr	est,		Approximate Interval Between
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	es us	by	Part II. Other significant condition	18 contributing to de	eath but not resulting	g in the un	derlying cause g	iven in Part I		23e. Did tot	acco use con	tribute to the	a cause of death?
ord	w requires been sign should be	ted	Diabetes mei	Tipus	ryperter	nsion	71			1 🗆 Ye	s 2 11 No	3 🗌 Proba	ibly 4 □Unknown
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<u></u>	Th ate pag	Col								perform	ned!//	death? 1 🔲 Yes :	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					of Death	(Check only on	9)		
oţ	Q: 12	. To	1 Yes 2 No 27. Manner of Death	28a. Date o		Outpatient o. Time of	3 LJ DOM			ne 5 Reside)
Division	ding Ph h. After th tuneral	tion	1 Natural 5 ☐ Pending	(Mont	h, Day Year)	Injury	28c. inju Wa	ork?]Yes 2.∐		8d. Describe ho	w injury occur	red	
isi	I or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could no	ot be	of Injury - At home,	farm stre				8f. Location (St	reet and Numb	ar or Puml	Pouto Number
Ö	P F F	Certification;	4 Homicide	buildir	ng, etc. (Specify)		o ,			City or Town	, State)	or or mular	riode rediliber,
	Hospital		29a. Certifier 1 Certifying	Physicien: To the	best of my knowled	lge, death	occurred at the t	ime, date an	d place, a	ind due to the ca	use(s) and ma	inner as sta	ted.
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Ex	xaminer: On the ba and mann	asis of examination a	and/or inve	estigation, in my	opinion, dea	th occurre	ed at the time, da	ite and place,	and due to	the cause(s)
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			Kathleen	W Stern	15		Dr	3207	3		7/8/0	5	Allerand
•	10		30. Name and address of person w	ho completed cause	e of death (Item 23a 0 610 egistrar's Signature	a) (Type, P	rint))		1		~ /
				Stem M	610	Nir	The Cive	· , R	run	BWICK	14d.	21	116
	F Stat		31. Date filed (Month, Day, Year)	2005 32.	egistrar's Signature	Sol	well						
	gistic	7,	JUL 14	2005	MELAN SO	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 19-19 19-11 11:00A 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 Month 9, July Richard Street Davis 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Harford Aberdeen 3541 Churchville Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/04/1939 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Months Days Hours Min. XXXM 2□F 65 Maryland 213-38-5322 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes XXNo Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3541 Churchville Road 21001 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2CMarried 1 Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Gas Station Owner 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Emma Braitmaier Walter B. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3541 Churchville Rd., Aberdeen, Maryland 21001 Pamela J. Davis (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.A. Ferris&Co., Inc. 07/11/2005 West Chester, PA ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. 333 South Parke St., Aberdeen, MD 21001 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a d ence of Due to (or as a consequence of):

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a State

10e. Street and Number

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If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Mudical Exametral matter to invitified at

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Division of Vital Records,

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Certification: To

law requires that the death certificate be executed Hospital or Attending Physician: funeral director, this After within 24 hours after death. To the Funeral Director: A the þ filled the 2

IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 24a. Was an autopsy performed' 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Cther: 4 ☐ Nursing Home 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 5 esidence 6 Other (Specify) 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

(Check only one) 29b. Signature and title o

29a. Certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

Year

7.11-65

BOR AIR MD ZIOLY

0 State

Medical

31. Date filed (Month, Day, Year) 4 2005 1

30. Name and address of pers

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o complete cause of death (Item 23a) (Type, Print)

and manner stated.

Registrar DHMH 17 Rev 1/2001

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	/Medi Examir		4a. Facility Name (If not institution, give	e street and numi	ber)		4b. City	, Town, or	Location of	of Death	oune 2		unty of Death	0.00	
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	3a or	۵	15808 Pine Croft	Lane				20716				USA			
	ms 2	Jera	11. Marital Status	12. Was Deced	ent Ever in U	J.S. 13.				gin? (Sp	ecify Yes or No Rican, etc.)		Race - Ameri		
9	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-1 show the Madical Esam at must be indiffied at	Ē	1 Never Married 2 Married	Armed Ford 1 XYes 2 If Yes, Give	es?		It Yes, spa 1 ☐ Yes			i, Puerto	Rican, etc.)		Black, White,	_{etc.} ite	
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	Health Health tem 27 i		Robert Davis/ So	n		323	Edger	nare	Drive	. Ar	napoli	s, MD	21403		
Baltimore,	Pages 1 are nent of Hea ent: if item ury or othe		20a. Method of Disposition 1		ate	Place of Dispo cemetery, crer Veter	natory or	other plac	ery		0/2005		ion · City or To enham,		
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0	ding Ph h. After th funeral		27. Manne of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		28c. Injury Work	at ?		28d. Describe I		curred		
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Division of Vital Records,	tel or Attending s after death. el Director: After ed in by the fune	Certification:	3 Suicide 6 Could not b	28e. Place o building	f Injury - At h , etc. <i>(Specil</i>	ome, farm, str fy)	eet, factor	y, office			28f. Location (3 City or Tox		umber or Rura	l Route Numbe	<i>∋r</i> ,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the b niner: On the bas and manne	is of examina	owledge, death ation and/or in	occurred estigation	at the tim	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) and date and pla	manner as st ce, and due to	ated. the cause(s)	
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			30. Name and address of person who MUHAMMAD AS	completed cause HRAF, ML	of death (Item	n 23a) (Type, 7// SA	Print) RV(S	AVE,	suite	100	RIVE	RDALE	, MO	2073	7
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NJM	() A	Decedent's Name (First, Middle	, Last)		00111	incate of	Dealli	2. Date of D	Reg. No.	2005	3. Time of Death
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	/Medica Examinei	4- 500-11)	4	b. City, Town,	or Location of Deat		4c.	2005 County of Deatl	1324
		Route 17 and H	armony Rd			Midd1	.etown		F	rederic	k
5	Funeral		6. Sex 7. A	ge (In yrs. last bi	N.	f Under 1 Year Months Days		(Month, D	irth av. Year)	9. Birth	place (State or Foreign
30	Director	038-60-4164 Usual Residence of Decedent		35	Yrs.			Apri1	22,1	970 Ind:	ia
4)	/land	10a. State 10b. County		10c. City, Tow	m or Loca	tion					10d. Inside City Limits
	Man Fined	Maryland Montgo	omerv	Gaithe	rshii	ra					1 ☐ Yes 2 🎇 No
	or 28,	10e. Street and Number		Jazene	. I D D G	10f. Zip Code			10g. Citi	zen of What Cou	untry?
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	72 hours after death with the Maryland natural, or items 23a or 28s-1 show disal Exercitive transfer publical at the profiled at all the public to the profiled at the public to the pub	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Wa	s Decedent of I	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	14. Race - Amer Black, White	
36	urs after	1 □ Never Married 2 Marrie 3 □ Widowed 4 □ Divorced	ed 1 □ Yes 2 🛣 If Yes, Give Year or Dates:	No		Yes ZXXNo		,		Specify: As 1	
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<u>×</u>	Ment Ment arked atic	Pulla Reddy Dand	lu				Ballaam	ma Kori	vi		
la_	2 shot and ls m	19a. Informant's Name/Relationsh		196	. Mailing /	Address (Street	and Number or Ru	ırai Route Numl	er, City o	r Town, State, Zi	p Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f ehow any injury grother traumatic event, the Medical Eventual must be notified at any injury grother traumatic event, the Medical Eventual must be notified at any injury or the modified at any injury or the market or the modified at any injury or the modif	Ugendhar Reddy I	oreddy / Fr	tiend 41	9 Wes	t Side	Dr. Apt.	202,Gai	thers	burg, M	D 20878
وّر		20a. Method of Disposition 1 □ Burial 2 XCremation		20b. Place o cemete	rv. cremat	on (Name or ory or other pla Cremate	ory July	Date 7 8,	20c. Lo	cation - City or T	own, State
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Ba	Depar Depar Impor any ir	fue de la	111.	00956	Th	ibadeau	Mortuary	Servi	e, P	.A.	20910
		23a. Part1. Enter the disease, or o	complications that cause	d the death. Do	not enter t	be mode of dvii	Ave., Lowe	er Level	Sil	ver Spri	Approximate
*	Physician	Immediate Cause (Final	my one cause on each i	ine.				or respiratory t	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Interval Between Onset and Death
Sec.	/Medical	disease or condition resulting in death)	a. Stroke Trib	alation a	ad The	mel Inj	ries				
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Division of Vital Records, P.O. Box 687	Physician: The law requires that the death certificate be extring that the death certificate by the attending physician rat director, page 2 should be detached for use as the buriant of the detached for use as the buriant of the completed by Physician/Medical E.	IF FEMALE:	23c. If yes, outcome	of pregnancy							
B	atten I for u	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		topic pregnancy her <i>(specify)</i>	/		2	3d. Date of deliv Month	ery Day Year
o <u>i</u>	the d	1 Yes 2 No 9 Unknown	9□ Unknown	t and or abatin	000	nor (specify)					
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ğ	quire an sig uld b							1 🗆	Yes 2□	No 3□Prol	bably 4 Unknown
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ita	cian: ertifice actor, p	25. Was case referred to medical					26. Place of Dea		2□No one)	1 X Yes	2 No
<u>></u>	hysic his ce it dire	examiner? 1 X Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2□ER/Ou	tpatient	3□ DOA Oth				⊠Other (Specia	V SCENE
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Ξ	after death Director: Lin by the	4 Homicide determin	ed 289. Place of Inf	ury - At home, fa c. (Specify)		factory, office		28f. Location (City or To	Street and wn, State)	Route 17	Harmony Road
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	he Hosp in 24 hou he Funel pletely fill edical	(Check only one)	Physician: To the best kaminer: On the basis of and manner sta	i examination an	dor invest	curred at the tin igation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	date and	and manner as s place, and due to	tated. o the cause(s)
	To the Hospital or Attending Physician: Th within 24 hours attendable. To the Funeral Director: After this certificate completely filled in by the funeral director, pagement of the funeral director of the fune	29b. Signature and title of certifier				29c. Licens			29d. Date	signed (Month,	Day, Year)
	7	7/1	JK.				CME			, 6, 20	
		30. Name and address of person w	no completed cause of d	leath (Item 23a) (Type, Prin	t)					
		THE CHOREM. K	Inf			TTT I	Penn Stre	et Bal	timor	e, Mary	land 21201
	State	31. Date filed (Month, Day, Year)	Registra	ar's Signature	back	2					
	Registrar	JUL 112	UUD BENNE	, St. A.							

		•	4 101	partment of Health and Men	ntal Hygien	0.0
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) EVELYN M. DobSon 4a. Facility Name (If not institution, give street and number)			ay Year 9. Twhe of Death? Year // Am M C. County of Death
	Funeral Director		Charlotte HALL Veteranis Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 777-30-1273 Usual Residence of Decedent	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Ju	MD Date of Birth (Month, Day, Yea, ine 14,	9. Birthplace (State or Foreign Country) Washington, DC
	itled within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-f show ant, the Madical Exter inser sust be multified at	Director	10a. State 10b. County 10c. City, Town or 1 MD Prince George's Clinton	Location	100.0	10d. Inside City Limits 1 ☐ Yes 2 ☑ No Citizen of What Country?
	s 23a or	erai Dir	5508 Spruce Drive	20735		USA
5-0036	ours after de rai', or item Execulcator	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica □ Yes 2X No Specify:	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0	be filed within 72 hours after death with the Marylan ital Hygtiene. Id other than "natural", or items 23s or 28s-f show other than "natural", or items 23s or cast show event, fre Madical Extending a standard at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Dccupation re kind of work done during most of working . DO NOT use retired) Homemaker	16b.	Kind of Business/Industry Own Home
aryland ?	be da fa	To Be C	17. Father's Name (First, Middle, Last) Paul James Hallock 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	18. Mother's Name (Fit Marie E illing Address (Street and Number or Rural Ro	Ethel Ch	naney
altimore, Ma	d 2 s th ar 7 is trau		Oscar F. Dobson (husband) 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 20b. Place of Disposered Computery, Cremetery, Cremeter	08 Spruce Drive Clin position (Name of ematory or other place) 1 Veterans Cem 2005	nton, MD	20735 Location - City or Town, State
Baltin	permit. Pages 1 an Department of Heali Important: If Item 2 any injury or other 2005e.		21. Signatura Juneral Service Licensee		neltenham, MD Home Calvert, PA Owings, MD 20736	
6	/Medical Examiner physician and physician and physician and physician and physician are physician are physician and physician are physician ar	Examiner	23a. Pkrt1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	ner the mode of dying, such as cardiac or res	int	Approximate Interval Batween Onset and Death
P.O. Box 68760	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medicai		B □Ectopic pregnancy 5 □ Other (<i>specify</i>)		23d. Date of delivery Month Day Year
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Division of Vital Records,	i: The law requicate has been r, page 2 should	Completed	•		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 22 No
of Vit	Physician: The this certificate had al director, page	To Be	25. Was case referred to medical examiner? 1 Yes			6 ☐Other (Specify)
ion		ertification;	27. Manner of Death 1 Natural 5 Pending 2 Accident Accident Accident Service (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)		Describe how inju	ury occurred
Divis	in the se	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal of the control of the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certifying Physician: To the best of my knowledge, deal of the certified Physician: To the best of my knowledge, deal of the certified Physician: To the best of my knowledge, deal of the certified Physician: To the best of my knowledge, deal of the certified Physician: To the best of my knowledge, deal of the certified Physician: To the best of my knowledge, deal of the certified Physician: To the best of my knowledge, deal of the certified Physician: To the best of my knowledge, deal of the certified Physician: To the best of my knowledge, deal of the certified Physician: To the best of my knowledge, deal of the certified Physician: To the best of my knowledge, deal of the certified Physician: To the best of my knowledge, deal of the certified Physician: To the best of my knowledge, deal of the certified Physician: To	ath occurred at the time, date and place, and investigation, in my opinion, death occurred a	due to the cause(it the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
)	To th within To th	Me	29b. Signature and title of certifies	29c. License number 0 0 0 6 / 1 4 7	29d. D	ate signed (Month, Day, Year)
	ID		30. Name and address of person who completed cause of death (Item 23a) (Type Mukesh Mathur, MD 110 Hospital Ro	· ·	k, MD 20	0678
	Sta Regist		31. Date filed (Month, Day, Year) JUN 2 9 2005 Signature	Sperke		

	_	Registrar		Maryland / D	Certificate of	Death	Reg	g. No.	
Physici /Medic	al	1. Decedent's Name (First, Middle, HARRY C. DOF	RSEY				2. Date of Death Month JULY 7	Day Year 2005	3. Time of Death 2002 P ^M
Examir	er	4a. Facility Name (If not institution, WASHINGTON COUR			HAGERS	or Location of Death	1	4c. County of Death	N
Funeral Director		236-72-0533	6. Sex 7. 1 □ X M 2 □ F	Age (In yrs. last birth	nday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 12/6/194	9. Birth Cou	place (State or Foreign Intry) VIRGINIA
show	7.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
r 28e-f show	Director	WV BERM 10e. Street and Number	KELEY	1	10f. Zip Code		10	g. Citizen of What Cou	
ust be		106 HESS AVI				25401		USA	
er, or iteme Examinar or	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 XXvorced	12. Was Decede Armed Force ed 1 XYes 2 If Yes, Give Year or Date	es? □No	13. Was Decedent of the lif Yes, specify Cub		pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify:	
hen "naturel" e Medical Ex	Be Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed) College (1-4	16a. (Decedent's Usual Occup (Give kind of work done life. DO NOT use retire CUSTODIA		rking	6b. Kind of Business/lu	
Itam 27 is marked other then other treumatic event. Ins M.	To Be Co	12 17. Father's Name (First, Middle, L CLAYTON L. I			COSTODIA	18. Mother's Nar	пе (First, Middle, Mi		
27 is marked of	-	19a. Informant's Name/Relationsh TONYA DORSEY	ip (Type, Print)		Mailing Address (Street B12 WOODBUR				
Important: if itam 27 i any injury or other tre	17	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp		ate cemetery	Disposition (Name of c, crematory or other pla BURG CREMATOR)		Date 2/2005	Oc. Location - City or T SMITHSBURG,	
Importa any inju		21. Signature of Funeral Service L	icensee - Blaw,	N	BROWN FU 327 W.	INERAL HO	ME, P.O. MARTINS	BOX 821, BURG, WV 2	5402
attending physicie for use as the but an/Medical	Ical Examiner	disease or condition resulting in death) Saluntially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or Due to (or	r as a consequence of	f):	ric card	Iovascura	disease	
	an/Med	IF FEMALE:	23c. If yes, outco						
y the attent ched for us	ysici	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Date of deliv Month	very Day Year
gned by the be detached	d by Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition	4 ☐ Pregnar 9 ☐ Unknow	th 2 Fetal death nt at time of death m	5 ☐ Other (specify) _	,		Month	Day Year the cause of death?
ate has been signed by the bage 2 should be detached	þ	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnar 9 ☐ Unknow	th 2 Fetal death nt at time of death m	5 ☐ Other (specify) _	,	1 Yes	Month Icco use contribute to 2 No 3 Pro 24b. Were aut	Day Year the cause of death? bably 4 □Unknown
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n. After this certificate has been signed by the funeral director, page 2 should be detached	Certification: To Be Completed by	in the past 12 months? 1	Hospital: 1 Ing. 28a. Date of (Month, atton and be ned 28e. Place or building g Physician: To the backgrammer: On the backgrammer: On the backgrammer:	th 2 Fetal death at time of death m th but not resulting in the but no	patient 3 DOA Office 28c. Injury M 1 Community M 1 Community M 29c. Licens 29c	26. Place of Deather: 4 Nursing Frat rk? Yes 2 No	24a. Was an autopsy perform Yes 2 ath (Check only one) Iome 5 Resident 28d. Describe how 28f. Location (Stree City or Town.	Month acco use contribute to 2 No 3 Pro 24b. Were aut prior to codeatb? 10 Yes 10 Yes 11 Yes 12 Yes 13 Yes 14 Yes 15 Yes 16 Other (Special Vinjury occurred) 17 Yes 18 Y	bay Year the cause of death? bably 4 Unknown opsy findings available ompletion of cause of 2 No fly) al Route Number, stated. to the cause(s) Day, Year)

DHMH 17 Rev 1/2001

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	Physici /Medic	al	1. Decedent's Name (First, Midd Maria de]	le, Last) os Angel	es Salazar	de C	ast	illo		2. Date of De Month July		2005	3. Time of D	-
	Examir	er	4a. Facility Name (If not institution Bowie Health		m <i>ber)</i>	4b. City, T	own, or Jie	Location of	of Death			County of Death		
705	Funeral Director	. Sie	5. Social Security Number 5 0 1 - 3 7 - 9 0 7 1	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. last birthday, 29 Yrs.	If Under 1 Months	Year	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da 0 9 - 2 8	th ly, Year)		place (State or ntry)	Foreign
·)	ow et		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or L	ocation							10d. Inside City	Limits
	Ba-1 sh	ctor	Pa. Ada	ıms	Ge	ttysb	urg						1 □ Yes 2	No No
	th with th	ai Dire	10e. Street and Number 1760 Shriver	s Corner	Rd. Lot 1	6 B		1732	25			en of What Cou	ntry?	
9036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked othar then "natural", or items 23e or 28a-f show other treumatic event, the Madical Examinatings the indiffied at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Mai 3 □ Widowed 4 □ Divorce	ried 1 ☐ Yes	edent Ever in U.S. 13. prces? 21 No ve ates:	Was Decede If Yes, specif 1 Yes 2		spanic Ori n, Mexican Specify:		ecify Yes or No Rican, etc.)		4. Race - Ameri Black, White, Specify: Hi:		
21215-0036	within 72 h lene. then "natu he Medical	Completed		nt's Education est grade completed) College ((Give	dent's Usual kind of work DO NOT use	Occupa done di retired)	ition <i>luring</i> mosi)	t of worki	ing	16b. Kin	d of Business/In	dustry	
213	is should be filed within h and Mental Hygiene. I is marked othar then "Ireumatic event, the Mer	Com	12		1-401 3+7	Home			4. No.	(F) . N. (1)		Domest:	ic	
land	ld be fi ental H ked otl ic ever	To Be	17. Father's Name (First, Middle Julio S	•				18. Mothe		<i>(First, Middle,</i> ita Ev		elista		
Maryland	and M sand M s mar	-	19a. Informant's Name/Relation	ship (Type, Print)					or Rura	I Route Numb	er, City or	Town, State, Zip		
	1 and Health 8m 27 ther tr		Raul Castill 20a. Method of Disposition	o, husba	20b. Place of Disp	osition (Name	e of	1		r Rd.		tysbur ation - City or To		7325
Baltimore,	Pages ent of nt: if it ry or o		1 Surial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (comptant cra	matory`or oth	er place		-8-			ysburg		
	Departit Pages 1 Department of Pages 1 Department of Pages 1 Department of Pages 1 Department if ite any injury or of April 1 Department if ite any injury or of the pages 1		Immediate Cause (Final disease or condition resulting in death)	r complications that of tonly one cause one a. Card: Tube	vis MoKIY caused the death. Do not en	ter the mode a foll	Br of dying	adbu g, such as ng Co	J. Iry cardiac o	Ave. Sor respiratory a	Smit! rrest,	Funera hsburg		1783 en
Box 68760,	eath certificate be executed attending physicien and for use as the burial-transit	Physiclan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	c	(or as a consequence of):						2	3d. Date of deliv	ery	
P.O. B	it the death by the atte tached for	hysicla	in the past 12 months? 1 Ayes 2 No 9 Unknown		nant at time of death 5{	⊒Ectopic pre ⊒ Other (spe						Month 5/05	Day Ye	ar
	w requires that the de been signed by the should be detached	ted by P	Obesity, Fatty		eath but not resulting in the u	underlying ca	use give	n in Part I.				se contribute to t	V	
Division of Vital Records,	2 3 3	e Completed by	25. Was case referred to medic	s)		-		00 51	(5	1 Yes	psy ormed? 2 \(\sum \text{No} \)	death?	ppsy findings av mpletion of cau 2 No	ailable ise of
f Vii	Physicie this cert al direct	To B	examiner? Yes 2 No	Hospital:	Inpatient XXER/Outpatie	nt 3 DOA	Othe	-		n <i>(Check only o</i> me 5□Resi		Other (Specif	(y)	
sion o	Jing After fune	Certification:	Z A /tooldonk	igation July	of Injury 28b. Time of Injury 4, 2005 6:09	\mathbf{P}^{M}		at ? ⁄es 2 🛣	No .	release	col	lapsed a om inner	tube	
Divi	i or Att after d Direct I in by	ertifi	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deteri	nined 286. Place build	e of Injury - At home, farm, st ing, etc. <i>(Specify)</i> nent park	reet, factory,	office		1_	City or To	wn, State)	Number or Rura 13710 Ce	al Route Numbe entral	Ave.,
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 ☐ Certify (Check only one) 2 X Medica	ng Physicien: To the Examiner: On the b	best of my knowledge, deal easis of examination and/or in oner stated.	th occurred a	t the time	e, date and inion, deal	d place, a	Largo, and due to the ed at the time,	cause(s)	and manner as s place, and due to	tated. the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifi	er 1/ 2 a	0 4			number				signed (Month,		
	6		30. Name and address of person	who completed caus	se of death (Item 23a) (Type		Popr	o C+∞	oot	Rol+in	Jul	Mary 1 22	005	1
	Sta	oto.	31. Date filed (Month, 2017) Yea	# KLL/	Registrar's Signature	7.7.7	1 CI II	.I DLL	eet	Dat (III	iore,	rar Argi	IU 212U	_
	Regist		501 1	4 2005	Eng. La									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2005 Virginia Elliott 28 4:27 June 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Wicomico Salisbury Wicomico Nursing Home If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2**X**) F Yrs 212-03-4707 93 9/8/1911 Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 Booth St. 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2XNo Specify: white

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parsons Cemetery

AM

16b. Kind of Business/Industry

Shirt Factory

Salisbury, MD

18. Mother's Name (First, Middle, Maiden Surname)

Mary Bell Shockley

5353 Royal Mile Blvd., Salisbury MD 21801
Disposition (Name of Date Date 20c. Location - City or Town, State

614 Easternshore Dr Salisbury MD 21804

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7/1/05

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

3 X Widowed 4 □ Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

L. Randolph Gordy

Everett Elliott/son

* 4 □ Donation 5 □ Other (Specify)

Streature of Funeral Service Licensee

19a. Informant's Name/Relationship (Type, Print)

15. Decedent's Education (Specify only highest grade completed)

1X Burial 2 ☐ Cremation 3 ☐ Removal from State

College (1-4or 5+)

Funeral

Director

"naturel", or items 23e or 28e-f show edical Examiner must be notified at

Pages 1 and 2 should be filed withIn 72 hours after onent of Health and Mental Hygiene.

Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natur any injury or other treumatic event, the Medical once.

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

Examiner physician and s the burial-trans Physician/Medical as the à Completed by cate has page 2 s Be

The law requires that the death certificate be executed Box 68760, P.0. Records, certificate Division of Vital Hospitel or Attending Physician: this After death. Director: 24 hours a

within 2 the

Registrar

22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 Wampson CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -YPOXIA disease or condition resulting in death) Due to (or as a consequence of): FAILURE PIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2X No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2X No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred Certification: Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mundal 00 60515

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahesha Thimmarayappa M.D. JUN3 0 2005

			For State		Maryland / D	epartment Certificate			• •	-	٥٣	00000
G	Physici	an	1. Decedent's Name (First, Middle,	TperMD, 6/29, , Last)	/05,BMW,MbCb	Jerinicale	or Death		2. Date of Dea		Vear	3. Time of Death
	/Medic	al	Dorothy East 4a. Facility Name (If not institution,	give street and nuc	nhar)	4h Cih, T	own, or Location	of Death	June 2	21, 200	5 ty of Death	7:45AM ^M
· ·	Examin	er	Hebrew Home Of				ville	101 Doain			gomer	у
	uneral rector		218-30-3666	6. Sex 1 □ M 2√x F	7. Age (In yrs. last birth 96 Y	Months	Year If Under Days Hours	Min.	8. Date of Birt (Month, Pay June 15	1909	9. Births Coul Sand	place (State or Foreign ntry) USKy, Ohio
/land	A T		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	10d. Inside City Limits
е Мал	la-f sh	ctor	MD Montg	omery	Boyd	5						★★Yes 2 No
with th	a or 2	Dire	10e. Street and Number			10f. Zip (10g. Citizen o	f What Cour	ntry?
death	ems 23	Funeral Director	17 Diller Cou		dent Ever in U.S.		0841 ent of Hispanic Or by Cuban, Mexica	rigin? (Spec	cify Yes or No-	Unite 14. R	d Statace - Americack, White,	tes can Indian,
s after	r, or it	by Fu	1 Never Married 2 Marrie 3 Widowed 4 Divorced		2 (⊋No e	1 ☐ Yes 2			noari, etc.)	Spec		nite
5-UU30 72 hours after death with the Maryland	rthan "natural", or items 23a or 28a-f show the Madical Examinar must be nutified at	ted	15. Decedent' (Specify only highes)	's Education	16a. [ecedent's Usual	Occupation	est of workin	ng.	16b. Kind of	Business/In	dustry
within iene.	than "	Completed	Elementary/Secondary (0-12)	College (1 4 yea	-4or 5+)	Give kind of work life. DO NOT use [eacher	retired)	St or Working		Virgin	ia Duk	olic School
H E	othe /ent,	Be Co	17. Father's Name (First, Middle, L			cacher	18. Moth	ner's Name	(First, Middle,			311C 3C1001
aryiand should be (ii) nd Mental Hy	arked atic e	ToB	Henry Parson						Sohling			
, Mar and 2 sh ealth and	Important: If item 27 is marked any injury or other traumatic events.		19a. Informant's Name/Relationsh Kathleen Walke			Mailing Address (Route Numbe		n, State, Zip	o Code)
ore, of Hea	Titem -		20a. Method of Disposition 1 □ Burial 2 □ Cremation		20b. Place of I	Disposition (Name crematory or oth			ate	20c. Location	- City or To	own, State
Saltimore, bermit. Pages 1 a Department of Hea	riant: r		`4x∑XOonation 5 ☐ Other (Sp	ecify)	Howard	Medica	1 School	6/21	/05	Washing	ton,	DC
Depart	any ii		21. Signature of Funeral Service L	licensee /	u A	Austi	Address of Facil	er Fun	eral H	ome	D.C.	20011
			21. Signature of Funeral Service L 23a. Part 1. Enter the disease of shock, or heart failure. List of	complications that ca	aused the death. De no	t enter the mode	of dying, such as	s cardiac or	respiratory ar	n i ng tor rest,	1, D	20011 Approximate Interval Between
	sician edical		Immediate Cause (Final disease or condition resulting in death)	a. Con	gestive	Heart	Failure	2				Onset and Death
	miner			Due to (scas a consequence of):						
pe	sit	iner	figure tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):						
5U, be executed	n and ial-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of):					_	
8/6U ate be e	physician and the burial-transit	dicai		d.								
Sertifi	attending p		IF FEMALE:	23c. If yes, out	come of pregnancy					224 [ate of delive	an,
g g	e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live bi	irth 2 Fetal death ant at time of death	3 Ectopic pred 5 Other (spec					onth (Day Year
hat the C	detached		9 ☐ Unknown Part II. Other significant conditio			he underlying car	use given in Part	1	23e Did to	nhacco use co	ntribute to th	he cause of death?
Ords, P	n signed b	d by	- Right Hume	Fue France	ture.		oso givoir ii r uit		1 🗆 Y		3 □ Prob	
§ ⇔	has been si je 2 should	Completed							24a. Was autop		. Were auto	ppsy findings available mpletion of cause of
_ €	pag			. ,					perfor	med? 2 No	death?	2□ No
OT VITAI Physician: T	is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 li	npatient 2□ER/Outp	atient 3 DOA	Othor	/	(Check only only only only only only only only		ther (Specif	(v)
	fter th	on; T	27. Manner Death 1 Limitural 5 Pending	28a. Date of	of Injury 28b. Ti	ne of 28	c. Injury at Work?		8d. Describe h			,,
or Attending of Attending	I Director: A d in by the f	Certification;	2 Accident investig 3 Suicide 6 Could n	ot be 28e. Place	of Injury - At home, farr	M n, street, factory.	1 Yes 2 office	_	8f. Location (S	Street and Nun	nber or Rura	al Route Number,
tal or /	erai Dire filled in b	Certi	4 Homicide	buildir	ng, etc. (Specify)				City or Tow	m, State)		
Lothe Hospital	교육	edicai	29a. Certifier 1 ☐ Certifying (Check only one)	g Physician: To the Examiner: On the ba and mann	best of my knowledge, usis of examination and	death occurred at or investigation, i	t the time, date ai in my opinion, dea	and place, as eath occurre	nd due to the o d at the time, o	cause(s) and n date and place	nanner as s , and due to	tated. the cause(s)
To the within	To the Fur completely	Me	29b Signature and title of a miner	Will	1		License number			29d. Date sign	ed (Month,	Day, Year)
			Julyan	TREGLE	MD, N		56414			June	21,2	2005
			30. Name and address of person v	who completed caus	of death (Item 23a) (T	1 6/21 1	Montroso	e Rd	Rockvi	lle. M	D 20	852
	Sta		31. Date filed (Month, Day, Year)	2005 H	egistrar's Signature	parte						V
	Registi	ar	JUN 29	7002	They we like							

Lloyd S. Ford 05 NJI

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M			For State Registrar	State of Mary	•	artment of Health and l rtificate of Death		0.0	
-	99 Å		Registrar Decedent's Name (First, Middle, Li	ast)	06	tillicate of Death	2. Date of Deat		23089
	Physici /Medic		L1ovd	Sylvester	Ford		July	5 2005	1025 M
	Examin	-	4a. Facility Name (If not institution, gi			4b. City, Town, or Location of Deat	h	4c. County of Deat	
			Civista Medica			La Plata		Charles	
	Funeral Director			Sex 7. Age (III	n yrs. la <i>st birthd</i> ay) 72 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Feb. 21,	Year) Co	hplace (State or Foreign
			Usual Residence of Decedent		12		reb.zi,	1933 Mai	ryland
	arylan ehow	J.	10a. State 10b. County	10	oc. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M.	Director	Maryland Char	cles		LaPlata 10f. Zip Code	1	0g. Citizen of What Co	
	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow ta Medigal Examinat roust be notified at	i Dir	6215 Bivins	P1aaa		20646		United Stat	,
	death	Funeral	11. Maritaf Status	12. Was Decedent Eve	r in U.S. 13.	Was Decedent of Hispanic Origin? (S ff Yes, specify Cuban, Mexican, Puen		14. Race - Ame	nican Indian,
98	or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ♠ No If Yes, Give		1 Yes 2 No Specify:	o rican, etc.)	Specify: B1a	
215-0036	hours tural',	ed by	3 Widowed 4 Divorced 15. Decedent's 8	Year or Dates:	162 Dogg	dent's Usual Occupation			
15	in 72 n na n na	Completed	(Specify only highest g	rade completed)	(Give	kind of work done during most of wo. DO NOT use retired)	rking	16b. Kind of Business/	industry
212	filed withi Hygiene. other then	E OC	12	Coflege (1-4or 5+)	Cons	truction Worker		Construct	ion
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las			18. Mother's Na	me (First, Middle, I	Maiden Sumame)	
Maryland	12 should be filed within in and Mental Hygiene. 7 is marked other then "traumetic event, the Mer	²	Joseph Fairfax F		10h Mail		e Brisco		7-0-4-1
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23s or 28s-f ehow other traumetic event, if a Medical Exercities from the notified at		Iviabelle C. Sau			ng Address <i>(Street and Number or Ri</i> Box 2092, Califo			
	f Heal f Heal item 2		20a. Method of Disposition		20b. Place of Dispo			20c. Location - City or	
E S	Page nent o int: if		1 ☐ Burial 2 【● Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		-	d-Echols Cr. 7-11	-2005	Charlotte H	lall. MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra ance.		21. Signature of Funeral Service Lio			2. Name and Address of Facility ${ t Br}$			
	#QE # 9		Edward N. Brinsii		00052 2	2955 Hollywood Ro	ad, Leona	ardtown, MI	20650-0279
			shock, or heart failure. List on	mplications that caused the y one cause on each line.	~ 1	ter the mode of dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
).	Physician /Medical		fmmediate Cause (Final disease or condition resulting in death)	a. Multy Due to (or as a)		y u His			
	Examiner			. Due to (or as arc	onsequence or):	/			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onsequence of):				
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.					
60,	be executed sician and burial-transit	-62		Due to (or as a c	onsequence or).				
687	death certificate t e attending physi d for use as the t	by Physician/Medic	330	d					
Вох	ih cert ending	an/M	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of a 1 Live birth 2 [Dectopic pregnancy		23d. Date of del	,
	e dea the att	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at tim		Other (specify)		Month	Day Year
P.0	w requires that the death been signed by the atte should be detached for	Phy	Part If. Other significant conditions	contributing to death but r	not resulting in the u	Inderlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Division of Vital Records,	requires t leen signe hould be (3	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		es 2□No 3□Pr	<i>(;</i>
000	s beer s shou	Completed					24a. Was a	in 24b. Were au	itopsy findings available
R	sician: The law certificate has t irector, page 2 s	mo					autops perform	med? death?	completion of cause of
/ita	clan: ertifica ector,	BeC	25. Was case referred to medical examiner?				ath (Check only or		
of \	ding Physiclan: n. After this certific funeral director,	<u>L</u>	Yes 2 No 27. Manner of Death	Hospitaf: 1 Information 28a. Date of Injury	2ER/Outpatie			ence 6 Other (Spe	cify)
o	fe fe	Certification:	1 □ Natural 5 □ Pending 2 ♣ Accident investigat	(Month, Day Y	ear) Injury	of 28c. Injury at Work?	siffet d	winjury occurred	him
Visi	Attending or death.	ifica	3 Suicide 6 Could not	be 28e. Pface of Injury	- At home, farm, st	Hours 4	281. Location (S	treet and Nymber or Ri	
ā	tal or s afte ai Dir ed in	Cert	4 Homicide	building, etc. (specify	24	City or Town	t Mong	and Highway
	Hospi 4 hour Funer ely fill	edicai	(Check only 2 X Medical Ex	aminer: On the basis of ex	amination and/or in	th occurred at the time, date and place avestigation, in my opinion, death occurred.	e, and due to the curred at the time, d	ause(s) and manner as	s stated, to the cause(s)
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	one) 29b. Signature and title of certifier	and manner stated	d.	29c. License number		29d. Date signed (Mont	
	F 18 F 8		1-110	11 %		OCME			• • • • • • • • • • • • • • • • • • • •
	M		30. Name and address of person who	o completed cause of deal	th (Item 23a) (Type	, Print)		July, 6, 2	
	y ~		THE OPONE MIKE			111 Penn Str	eet Bal	tımore, Mar	ryland 21201
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1.0			-
Di	MH 17 Bey 1/2	- 2	301. 0	- 500b	15.	gues .	<u></u>		

Registrar DHMH 17 Rev 1/2001

			1 _ Stote		artment of Health and l rtificate of Death	Mental Hy	giene	
		164	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)	061	incate of Death	2. Date of De		5 23090
	Physicia /Medic		Frederick W. Ford			June	26, 200	5:55 P ^M
	Examin	.6	4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or Location of Deat	1	4c. County of	
	<u> </u>	1	Prince Georges Hospital 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	Cheverly If Under 1 Year If Under 24 Hrs.	8. Date of Bir	Prince	
	Funeral Director		250-22-4417 ^{1X M 2 F}	78 Yrs.	Months Days Hours Min.	Sept.	10, 1926	Birthplace (State or Foreign Country) North Carolina
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Maryli f sho	tor	D.C. N/A	Washingt				X Yes 2 No
	or 28a	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of Wha	
	eth wi		1505 Kalmia Road, N.W.		20012		United	
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or items 23e or 28e-f show many injury or other traumatic event, the Medical Examinant in an inclined at anotes.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 12. Yes 2 14. Yes 2 15. Yes 2 16. Yes 2 17. Yes 2 18. Yes 2 19. Yes 3 19. Yes 2 19. Yes 2 19. Yes 3 19. Yes 3 19. Yes 2 19. Yes 3 19. Yes 3 19. Yes 3 19. Yes 3 19. Yes 4 19. Yes 3 19. Yes 4 19. Yes 5 19. Yes 6 19. Yes 7 19. Yes 7 19. Yes 8 19	□No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes	pecify Yes or No o Rican, etc.)		American Indian, White, etc. Black
2-0	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of wo	rking	16b. Kind of Busin	ness/Industry
121	within ene. than	duic	Elementary/Secondary (0-12) College (1-4	or 5+) Seni	DO NOT use retired) Or Investigator Stice Department		Federa	1 Government
פ	Il Hygid other	BeC	17. Father's Name (First, Middle, Last)	7 343		ne (First, Middle,	, Maiden Sumame)	
ylar	should be and Mental s marked o	To E	Ernest Ford, Sr.		Estelle			
, Maryland	Health and temporal tem 27 is m		19a. Informant's Name/Relationship (Type, Print) Martha Ford Gladden /sis		ng Address (Street and Number or At Kalmia Road, N.W.			
Baltimore,	Peges 1 and of He and of H		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from St. '4 □ Donation 5 □ Other (Specify)	are !	osition (Name of matory or other place) Like Crematory 6/2	Date 9/05	20c. Location - Cit Beltsvil	
Balti	permit. Peges Department of I important: If ite any injury or of		21. Signature of Funeral Servicensee		2. Name and Address of Facility Mo			
D	B. B.		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	ised the death. Do not ent				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	5 JYNDRON	1E			Onset and Death
	/Medical Examiner		resulting in death) Due to (or	as a consequence of):	INFECTION			
3()	Ä,	Je.		as a consequence of):	7,77			
	icate be executed physicien and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. VENTIL Due to (or	17 5.11	NDENT			
60,	icate be executed physicien and s the burial-transit	al Ex	Due to (or	as a consequence of):				
68760,	ficate g phys	edical	d					
Box	death cert e attending d for use a	Physiclan/M	1 Ves 2 No 4 Pregnar	h 2 ☐ Fetal death 3 ☐ nt at time of death 5 ☐	□Ectopic pregnancy □ Other (specify)		23d. Date of Month	
P.O.	at the	Phys	9 Unknown 9 Unknow			nne Dide		.t. to the course of death?
	quires then signed and be d	by	Part II. Other significant conditions contributing to dea INSECTED STAGE IX	DECUBITI	inderrying cause given in Part I.			ite to the cause of death? ☐ Probably 4 ☐ Unknown
Records,	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed				24a. Was auto perfo 1 \(\text{Yes} \)	psy prio prmed? dea	re autopsy findings available in to completion of cause of th?
/ita	cian: ertifica ector, I	Be	25. Was case referred to medical examiner?			ath (Check only o		
6	Physic this c	.T	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Ing. 27. Manner of Death 28a. Date of				dence 6 Other	(Specify)
on	ding th. : After s fune	tlon	1 ⊠ Natural 5 □ Pending (Month, 2 □ Accident investigation	Day Year) Injury	of 28c. Injury at Work? M 1 Tyes 2 No		now anjury occurred	
Division of Vital	or Atter after dea Director	Certification:	3 Suicide 6 Could not be 28e. Place o	f Injury - At home, farm, st g, etc. (Specify)	reet, factory, office	28f. Location (City or To		or Rural Route Number,
	Hospita 24 hours Funeral stely filled	Medical C	29a. Certifier (Check only one) (Check only one) 1 Certifying Physicien: To the base and manne	is of examination and/or in	th occurred at the time, date and place execution, in my opinion, death occurred.	e, and due to the arred at the time,	cause(s) and mann date and place, and	er as stated. If due to the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (/	Month, Day, Year)
)	10		· Gull al	inno	72757-	7	06/2	6/05
	<i>ω</i> -		30. Name and address of person who completed cause DR OPHNELL CUMBERBATO	H 3001	HOSP, TAL DE	Cake	EVERLY, M	D 20185
	Sta Reg ist		31. Date filed (Month, Day, Year) JUN 2 9 2005	gistrar's Signature	refer			

			For State Registrar	State of Ma	ryland /		rtment					Reg. No 1	15	23091
	Physici		 Decedent's Name (First, Middle, Last) Kathryn Marie F 	owler							2. Date of De. June 2	28 ^D 2 005	Year	3. Time of Death 7:25 Ам
	/Medic Examin		4a. Facility Name (If not institution, give s Calvert County	treet and number)	Cent	er	4b. City, 1 Princ		Location o	of Death		4c. County of	of Death	.1
	Funeral Director		5. Social Security Number 6. Sex 218-40-8865	7. Age	(In yrs. last t	oirthday)_ Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month Da April	14,1912	9. Birthi Coul Mary	place (State or Foreign ntry) Land
	Maryland I-f show	tor	10a. State 10b. County Maryland Calvert		10c. City, To Princ			ck						10d. Inside City Limits 1 ☐ Yes 2 🛂 No
	or 288	Funeral Director	10e. Street and Number				10f. Zip					10g. Citizen of W		•
	eath w	erai	1715 Lottie Fowler	Road 2. Was Decedent E	vor in LLC	12 14	/as Dasad	206		nin2/Cno	W. Van as Na	United		
980	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural", or Itams 23a or 28a-f show event, itte Medical Examiliner count.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:		1	Yes, speci		Specify:	gin? (Spec i, Puerto R	offy Yes or No- lican, etc.)	Specify:	, White,	can Indian, etc. lite
Maryland 21215-0036	within 72 ho ene. than "natu he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+	.)	(Give k life. D	ent's Usual ind of work ONOT use naker	k done d e retired,	ition uring most	t of workin	g	16b. Kind of Bus		dustry
land 2	should be filed within Ind Mental Hygiene. s markad other than 'umatic event, the Mental than '	To Be Co	17. Father's Name (First, Middle, Last) James Sollers								(First, Middle, Langl	Maiden Sumame		
Mary	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 Is marked any injury or other traumatic es ance.	-	19a. Informant's Name/Relationship (Type David E. Fowler- se	•								r, City or Town, S Frederi		Code) 20678 Maryland
Baltimore,	Pages 1 annont of Heann of Itam		20a. Method of Disposition 1 Statistical 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place cernet St. P	of Disposi tery, cremi auls	ition (Nam atory or oti Epis	e of her place COPS	une I Cer	30 20 neter	05 Y	20c. Location - (Prince Fre		own, State ok Maryland
Balt	permit. Departr Imports any injs		21. Signature of Eugeral Service License	5		100						ral Home ublic Mary	land	20676
	Pnysician /Medical Examiner	<u>.</u>	23a. Pant1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a	emen: consequence beter	e of):	r the mode	of dying	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
oʻ.	icate be executed physician and s the burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a		e of):								
8760,	icate be physicia s the bur	edical	d	Col	agestiv	/ €		ear	T	Fai	lon			
.O. Box 6	death certifi e attending ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 □	ic. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at to 9 □ Unknown	l 🗌 Fetal déal		Ectopic pre Other (spe					23d. Date Mont		ery Day Year
ecords, P.	sign sign d be	by	Part II. Other significant conditions conf	ributing to death but	not resulting	in the und	derlying ca	use give	n in Part I.			obacco use contrib res 2 □ No 3		ne cause of death?
Œ,	The ate ha	Completed								_	24a. Was autop	med? pr	ior to cor	psy findings available mpletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				Othe		of Death	Check only o	пе)		
of	ding h. After fune	atlon: To	1 Yes 2 Mo ''' 27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b.	Outpatient Time of Injury		c. Injury Work	4 NUI	28		ence 6 Other		y)
Division	al or Attandi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, stree	et, factory,	office		28	Bf. Location (S City or Tow	treet and Number n, State)	r or Rura	l Route Number,
	To tha Hospital or At within 24 hours after d To tha Funaral Direct completely filled in by	edical	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of er: On the basis of and manner state	examination a	ge, death and/or inve	estigation,	in my op	inion, deat	d place, an	d due to the o	ause(s) and man date and place, ar	ner as st nd due to	ated. the cause(s)
)	To tha within To tha	Σ	29b. Signature and title of certifier Similar	MD			1 .	License D S	number	0	1	29d. Date signed $6 - \hat{\alpha}$		
	10		30. Name and address of person who cor	npleted cause of de	Hosp	RD	1	Poi	n Ce	Fo	edevial	MD	-	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 9	32. Registr	s Signature	K	ho	E						

			For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of H tificate of L			iene	20000
	9	inion	Decedent's Name (First, Middle, La					2. Date of Dea Month	Day Year	S. Timed Destinati
		dical	LOUIS	KENNET	!H	GROSS	Location of Death	July_	9 2005 4c. County of Deat	11:56 M
	Exan	niner	4a. Facility Name (If not institution, given the sapea)		l Center		el Air		Harf	
	Funer Directe			7. Age	(In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3/28/	1913 9. Birt	hplace (State or Foreign unity) aryland
•	pus *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			. ,	10d. Inside City Limits
	Maryla f sho	to		ford		Jarre	ttsvill	e		1 ☐ Yes 2 No
	th the or 28e e notifi	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	
	ath will	rai	3911 Madon			Mar Dandani of U	21084	pacify Vac or No-	United	
356	I I Z I 5-UU30 4 within 72 hours after death with the Maryland jiene. r then "natural", or Items 23a or 28e-f show r then "natural", or Items 23a or 28e-f show	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	lo	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	Rican, etc.)		
2300	2 hou satura	ted	15. Decedent's l	ducation	16a. Dece	dent's Usual Occup	ation during most of work	king	16b. Kind of Business	
č		nple	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retired	d)			Dept. of & Parks
Š	0 0 0 .		10 17. Father's Name (First, Middle, Las	<u></u>		Superint		ne (First, Middle,	Maiden Sumame)	0 202
		To Be		Alber	t G	ross	Luel	la	Mae	Troyer
	re, Maryland s 1 and 2 should be t f Health and Mental I item 27 le marked o other treumatic eve	-	19a. Informant's Name/Relationship			-				Zip Code) 21084
05	e, M6 1 and 2 Health a tem 27 le		Marlene G. Ke	gley/Dau	ghter 22.		on Mill	Rd.	Jarretts 20c. Location - City or	ville, Md.
19/0	Baltimore , permit. Pages 1 ar Department of Healmportent: If item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3		cemetery, cre	matory or other pla	/			
7	Baltimor permit. Pages Department of Importent: If it		* 4 □ Donation 5 □ Other (Special Signature of Fune a) \$7 rvice \$100.	1 - 2 - 1	-	Cemeter: 2. Name and Addre			madonna, sville, M	Maryland
	Depart Impo	once	VIII Hereld	en Kurt	سلنت (neral Hom	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each fi	the death. Do not en	iter the mode of dyi			rrest,	Approximate Interval Between Onset and Death
	Pnysici /Medic		Immediate Cause (Final disease or condition resulting in death)	a Myoca	a consequence of):	stanction	on Acu	te		5 minutes
	Examin			b. Ische	41	art Dis	ease			10 yeas
70	3 P = 5	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					, ,
007	8760,	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
056	8760, cate be exp				,					
#C	687 tificate ng phys	olbe		d						
	Box ath cer attendir	Jan/A	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐Ectopic pregnand☐ Other (specify) _	y ————————————————————————————————————		23d. Date of de Month	alivery Day Year
	that the de	Phy	9 ☐ Unknown Part II. Other significant condition		aut not resulting in the	underlying cause g	ven in Part I.	23e. Did 1	tobacco use contribute	to the cause of death?
	dS, irres th			Melanon		311301171113 02000 3		1 🗆	Yes 2□No 3□F	robably 4 Dunknown
	cord:	va betellamo	- riarrightans					24a. Was	an 24b. Were a	autopsy findings available completion of cause of
	I Rec							auto perfo	ormed? death?	
	Vital F sicien: Th certificate		25. Was case referred to medical		, _		26. Place of De	ath Check on	one	
Louis	of V Physic this ce	Ē	1 ☐ Yes 2 ☐ Yo		ent 2 ER/Outpati	ent 3 DOA			idence 6 Other (Sp	ecify)
10	JI O O		27. Manner of Death 1 Natural 5 Pending investiga		ury 28b. Time ay Year) Injury	, Wo	ork?]Yes 2∐No	200. Describe	now injury occurred	
,2502	Division of Vital Records, To the Hospitel or Attending Physicien: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe		2 Accident investigated a Suicide 6 Could not determine	ot be 28e. Place of Ir	njury - At home, farm, s tc. (Specify)			28f. Location (City or To	(Street and Number or F wn, State)	Rural Route Number,
Gre	Hospitel 24 hours a Funerel D	cary miled	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the bes	of examination and/or	ath occurred at the investigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time.	cause(s) and manner a , date and place, and di	as stated. ue to the cause(s)
	o the Pithin 2	eidwo	one) 29b. Signature and title of certifies	and mariner s	f	29c. Licer	nse number		29d. Date signed (Mor	nth, Day, Year)
	To With	ŏ	1	peraly/		Do	059387		7/10/0	5
	10		30. Name and address of person w	and the second second	death (Item 23a) (Typ	e, Print)			m 1 11 1	5 1, MD 21050
	13		Aly Nage	ib MD	2 Colgat	e Drive	Suite	203.	torest Hill	1,111) 21050
	Re	State aistra		nn5 Fully	trar's Signature	ares,				

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			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H			giene Reg. No D	ns	23002
	Physici /Medic		Decedent's Name (First, Middle, Las WILLIAM SHERM	IAN GR	OVE SR.			2. Date of Dea Month JUNE	24	2005	11:40A M
	Examir	er	4a. Facility Name (If not institution, give 38426 LAUREL RIDG 5. Social Security Number 6. Se	GE COURT	a (In yrs. last birthday,	4b. City, Town, or MECHANIC		Date of Birt	ST.	y of Death MARY 1	_
	Funeral Director		220-09-5713 Usual Residence of Decedent	☑M 2□F	86 Yrs.	Months Days	Hours Min.		v. Year)	WASH	place (State or Foreign http) INGTON, DC
	he Marylan 28a-f ahow	Director	MD CHARLES 10e. Street and Number		10c. City, Town or L				10 - Citin		0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or	Dir	1103 CORNELL LAN	₹.		10f. Zip Code 20602			10g. Citizen of		itry?
900	d within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28a-f ahow It a Madical Examinar rust be realited at	by Funeral	11. Marital Status 1 Never Married	12. Was Decedent i Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	10	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 25000	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		ce - Americack, White,	
21215-0036	f within piene. r than "	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired IEER	during most of wo		16b. Kind of E		
Maryland 2	ges 1 and 2 should be filed tho of Health and Mental Hygi If item 27 is marked other or other traumatic event,	To Be C	17. Father's Name (First, Middle, Last) EUGENE GROVE		'			me (First, Middle, LEE STRE)	Maiden Suma		
Mar	d 2 should the and 7 is mutraum		19a. Informant's Name/Relationship (7) BRENDA V. PADGETT			ng Address (Street a					
Baltimore,	Pages 1 and 3 nent of Health ant: If trem 27 art or other tr		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	20b. Place of Disp cemetery, cre	HOLLYBAN position (Name of matory or other plac IEM. GRDNS	e) JUN	E ^{Date} 29, 2005	20c. Location WALDOR	- City or To	own, State
Baltir	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen		2		ss of FacilityBR	INSFIELD-	-ECHOLS	FUNL	.HME.,P.A.
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. So_	10.	Artuy			rest,		Approximate Interval Between Onset and Death
8760,	eate be executed hysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of):	Artery	Dise	ane			
.O. Box 687	The law requires that the death certificate I the has been signed by the attending physionage 2 should be detached for use as the	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				ate of delive	ery Day Year
s, P	quires that n signed b uld be deta	by	Part II. Other significant conditions of				en in Part I.	23e. Did to			ne cause of death?
Vital Record	The law requires tate has been single 2 should I	Completed	Type two	Diale	yperter	allitus	2	24a. Was autop perfo 1 Yes		prior to cor death?	psy findings available impletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe		ath (Check only o			DAHCUTED ! C
of	nding Physath. r: After this e funeral dii	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 2 ER/Outpatie ry 28b. Time (y Year) Injury	of 28c. Injury Work		dome 5 ☐ Resident 28d. Describe h			_{y)} DAUGHTER'S SIDENCE
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After I completely filled in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, s c. (Specify)	reet, factory, office		28f. Location (5 City or Tox		ber or Rura	l Route Number,
	e Hospital or 124 hours after Euneral Directory filled in Kleich	edical	29a. Certifier (Check only one) Check only	ysician: To the best niner: On the basis o and manner st	of my knowledge, dea f examination and/or in ated.	th occurred at the time evestigation, in my of	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place	anner as st	ated. the cause(s)
	To the Hos within 24 ho To the Fun completely	Med	29b. Signature and title of certifier		1. M - W	29c. License	o number 03529	5	29d. Date sign	,	
9	DB/ = 1		30. Name and address of person who SATISH N. JUMANI		leath (Item 23a) (Type		'E #208 Т	WALDORF.	JUNE 2		
	Sta Regist		31. Date filed (Month, Day, Year) JUN 2 9	32. Registr	ar's Signature			100			

			r lease 1					_	•	•
			1 For State	State of Marylar				lental Hygic	ene	
	450		Registrar		Cer	tificate of	Death		No2 1 1	23091
	Physicia	an	1. Decedent's Name (First, Middle, Last)	1	/	1-		2. Date of Death Month	Day Yea	3. Time of Death
	/Medic		Ninnie	Layte	on (JOGF.	Rey	JUNE	26,200	5 8.45 AM
	Examin	er	4a. Facility Name (If not institution, give st	reet and number		4b. City, Town, o	r Location of Death		4c. County of De	
				eneral Ho		Can	1bridge	2		rester
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H/s. Hours Min.	8. Date of Birth (Month, Day, Y	9. B	irthplace (State or Foreign Country)
	Director		X 1 x - 1 x - J 1 J X	83	Yrs.			Feb.06,	920 N	laryland
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	lanyl sho	ō	MD Dank	colone 1	2	10010				1 PYes 2 □ No
)	with the Maryland tor 28a-1 show be notilied at	Director	10e. Street and Number	STERI	ami	DKI COde	6	100	. Citizen of What	
)	death with the Maryland rns 23e or 28a-f show ritust be notified at		7001	1.4		101. 219 0000	112	109	1 /	A Southly !
)	eath	Funerai	11. Marital Status	2. Was Decedent Ever in U	lace	Vas Decedent of H	lienanic Origin? (Sp.	acify Vas or No-	14 Baco A	merican Indian,
	ter d	Ë	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No			lispanic Origin? (Spa an, Mexican, Puerto	Rican, etc.)	Black, WI	nite, etc.
36	hours after death with tural', or Items 23e or al Examiner must be	by	3 ☑Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify: B	lack
2-0036	g 3 a	bed	15. Decedent's Educ	ation	16a. Deced	ent's Usual Occup	ation	16	b. Kind of Busines	
2	within 72 ene. then "nat	pie	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done OO NOT use retired	during most of work: d)	ing		,
212	r the	Completed	Clementary/Secondary (0-12)	College (1-4or 5+)	0	leric	al	10	athal:	c Church
ğ	be filed wil tal Hygien d other th	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
land	lid be lental rked c	ToB	William	Kiah			Hele	11/1	150n	
Mary	should and Men s marke umatic		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street	and Number or Rura	al Route Number, C		, Zip Code)
	and 2 saith a n 27 is		Davette As	Kins	2416	Sambo	2 doe Be	Itway C.	ambrida	e.MD.21613
ē,	- I 9 =		20a. Method of Disposition		Place of Dispos	sition (Name of natory or other place	1		c. Location - City	or own, State
Baltimore,	Pages nent of int: If It iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	thel (0110 1010	y 17/2	2/050	ambridg	· Mary land
=	E 65 2		21. Signature of Funeral Service License	100	22	Name and Addre	s of Facility			
ñ	permit. Departimport sany inj once.		> Fanelle	C. Hen	W H	enry F	nington	Home	his dag	MD 21613
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dea	th Do not ente	er the mode of dying	ng, such as cardiac o	or respiratory arrest	pri egy	Approximate
	Dhysisian		Immediate Cause (Final					-	padens	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Meelia. Due to (or as a consec	sprace off:	and	11000001	sa you	gucienc	rary
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	uted d ansit	m.	Cause (Disease or injury that initiated events							ī
Ť,	be executed siclen and burial-transit	Examiner	resulting in death) Last	Due to (or as a consec	uence of):					
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99									1	
Ř	death certifica e attending ph ed for use as th	2	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregn		F. (2)			23d. Date of d	elivery
ñ	death a atte d for	icia	in the past 12 months? 1 Yes 2 No	1 Live birth 2 Feta 4 Pregnant at time of c		Ectopic pregnancy Other (specify)	,		Month	Day Year
Ö	that the de led by the detached	Physician/Med	9 □ Unknown	9□ Unknown						
ر ح	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions cont	ributing to death but not res	sulting in the ur	iderlying cause giv	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
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T E	The law sate has b page 2 si	Completed						autopsy performe	prior to d? death?	completion of cause of
VIta		e C	25. Was case referred to medical				OC Plans of Parit	1 Yes 2	No 1 L Y€	es 2 No
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o	Phys	-	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur	WHAT I	28d. Describe how		ecity)
DIVISION	tending leath. tor: After the funer	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor M 1□	k? Yes 2 □ No		,	
<u> S</u>		fica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, fam, stre	et, factory, office	T	28f. Location (Stree	at and Number or I	Rural Route Number,
É		Certification:	4 Homicide	building, etc. (Speci	fy)			City or Town, S	State)	
	To the Hospital or Al within 24 hours after of To the Funerel Direc completely filled in by		29a. Certifier 15 Certifying Physi	cian: To the best of my kno	owledge, death	occurred at the tin	ne, date and place.	and due to the caus	e(s) and manner	as stated.
	ne Ho 124 t ne Fu letels	edlcal	(Check only 2 Medical Examination)	or: On the basis of examina and manner stated.	ation and/or inv	estigation, in my o	pinion, death occurr	ed at the time, date	and place, and di	ie to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	- 1 mh		29c. Licens			Date signed (Moi	
)	511110		Do	005665	9	6/26	105
			30. Name and address of person who con MulsammAD	npleted cause of death (Iter	n 23 <u>a)</u> (Type, I	Print)			•	100 011
			MUHAMMAD	AFZAL	300	HUROR	4 57, 6	AMBR	1046	111) 216/3
	Sta	te	31. Date filed (Month, Day, Year) 2 8	2005 ^{22. Regisfrar's Sign.}	ature 🛵	A. Au				
	Registr	ar	JUN 6 8	A COLOR	9 15 1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Harriett Mildred Groom June 27 2005 8:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 X F Months **Director** 510-30-8953 73 August 11,1931 Kansas Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 shov injury or other traumatic event, the Madical Examinar must be multified at 1 ☐ Yes 2X No Directo Maryland Frederick Monrovia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 12278 Weller Road 21770 Funerai United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify. 3 → Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail Sales and Mental Hygir 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I unt: If Item 27 is marked o James E. Pettit Georgia L. Pentecost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kris Alcorn/ Daughter 12278 Weller Road, Monrovia, Maryland 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. June 29,05 ' 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Metropolitan Crematoriun Inc. 22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 21. Signature of Juneral Service Licensee odle 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complicator's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORUNARY AR TERY DISGREE **Physician** waro disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Polymyalgia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy actulia dit atri performe Chront certificate Strozen or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident after death filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/28/ 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Md. 21702 Ave #204 S. Gr:550m (W) 1475 1angy 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 3 0 2005 Registrar

		1 - State Registrar 1. Decedent's Name (First,	Middle, Las	st)	Ce	ertificate o	f Death	2. Date of D	Reg. No	005	2309
ysicia	an	EDITH RUT						Month	Day 38	Year	-o. Iwilowi zpali
Medic: camine		4a. Facility Name (If not inst				4b. City, Town	n, or Location of De			JOOS unty of Death	7 .
		PENIONIA ROGI	DAM	Medical	CPNYU	54	1/1sbury			HICON	MICO
eral		5. Social Security Number	6. Se	ex 7. Age ☐ M 2[X F	e (In yrs. last birthda) Yrs.	Months Day		in. (Month, D	ay, Year)	Col	oplace (State or Fore untry)
ctor	-	267-12-2685 Usual Residence of Decede	nt		82			OCT.25	,1922	LAKE	LAND, FL
7		10a. State 10b. Co	ounty		10c. City, Town or I	_ocation					10d. Inside City Limi
the Medical Examiner must be notified at	Director		USSEX		REНОВО	TH BEACH					1 Tyes 2 X
De C		10e. Street and Number				10f. Zip Code	9		10g. Citizen	of What Cou	untry?
THE STATE OF THE S	by Funeral	701 STONEY	BROOK	12. Was Decedent 8	Ever in U.S. 13	. Was Decedent o	of Hispanic Origin?	(Specify Yes or N	USA 14. I	Race - Amer	ican Indian.
age of	필	1 ☐ Never Married 2 ☐	Married	Armed Forces? 1 ☐ Yes 2 😿 N		If Yes, specify Co	uban, Mexican, Pu	erto Rican, etc.)		Black, White	
Exa	d by	3 Widowed 4 □ Div	orced	If Yes, Give Year or Dates:		1∐ Yes 21 N	lo Specify:		Spe	ecify: WH	ITE
dice	Completed		edent's Ed lighest gra	lucation de completed)	(Giv	edent's Usual Occ e kind of work dor DO NOT use reti	ne durina most of w	vorking		f Business/l	ndustry
De M	dmo	Elementary/Secondary (0	12)	College (1-4or 5	+)			тестоп		Y OF	1.0T DD
+="	Be Co	17. Father's Name (First, Mi	ddle, Last)		DANU	SIAND PRO	18. Mother's N	AECTOR lame (First, Middle			ACH, DE
	OB	WALTER COO	PER				(UNKNO	OWN) SHA	AW		
othar traumatic		19a. Informant's Name/Rela	tionship (7	Type, Print)	19b. Mai	ling Address (Stre	et and Number or		ber, City or To	wn, State, Zi	ip Code)
nar tr		SUSAN BARE	FOOT/	DAUGHTER	144	RANDALL	DRIVE, W.		IA, SC	2917	2
or ot		20a. Method of Disposition 1 Burial 2 Crema	tion 3 □	Removal from State	20b. Place of Disp cemetery, cre	oosition (Name of ematory or other p	olace)	Date	20c. Location	on - City or T	Town, State
lury		° 4 ☐ Donation 5 ☐ Oth			DELAWARE	VETERANS	S CEM. 07	/05/05	BEAR	DELA	WARE
any injury once.	1	21. Signature of Funeral Se	ryice Licen	see	P	ARSELL F	tress of Facility HO	OMES & CI			
e 0	1	1 Sec		aresy	11.	COCI DIN	CC HICHIA	AY, LEWES	e ne	100EO	
					the total Desire	0301 KTN	GO UTGUM	TI O LINE) UE	19300	
			se, or comp List only	olications that caused one cause on each lin	the death. Do not en	nter the mode of d	tying, such as cardi	iac or respiratory	arrest,	19930	Approximate Interval Between Onset and Death
sian lical		23a. Part : Enter the disea: shock, or beart failure. Immediate Cause (Final disease or condition resulting in death)	se, of comp List only	a. Acli	the death. Do not en	nter the mode of d	tying, such as cardi	iac or respiratory	arrest,	19930	
cian lical iner		Immediate Cause (Final disease or condition resulting in death)	(a. Acli	the death. Do not en	nter the mode of d	tying, such as cardi	iac or respiratory	arrest,	19936	Interval Between
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amended 28c per dr/wichd/ Certificate of Death 6-28-05/d1seg. Noc) 1. Decedent's Name (First, Middle, Last) a tineo Depth 2. Date of Death Day **Physician** Month Hollana 0/0 0533 M 66 05 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1Com100 Nedical Contr shun 11/151/16 alona Sa If Under 24 H/s. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□M 20 F Hours 217-28-3408 73 Yrs. Director Mary land Usual Residence of Decedent 10a. State Count 10c. City, Town or Location 10d. Inside City Limits iges 1 and 2 should be filed within 72 hours after death with tha Marylan in of Heatih and Mental Hygiene.
It of Heatih and Mental Hygiene.
It item 27 is marked other than "neturel", or Itame 23e or 28e-1 show or other traumatic event, Its Madical Examina must be notified at Assawoman Accomac 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12244 23302 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Postal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sylvester shockley Annie Shockley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12244 Atlantic Rd HSSawoman, VA Holland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 PBurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Assawaman Churchyard 6-28-05 Assawoman, VA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fox Funeral Home Pobox 278 Temperanceville VA 23442 ames 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Pokre /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine to (or as a conseque ce been signad by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 Z No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Yes Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**X** No 1 MInpatient 2 ER/Outpatient 3 DOA o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 Natural death. 1 Tes after death 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Walker

31. Date filed (Month, Day, Year)
LUN 2 8 2005

Carroll

strar's Signature

Salisbury MD

			for State Registrar	State of Ma		artment of F				
			Negistrar Decedent's Name (First, Middle, La	st)		Timodic or i	Doutt	2. Date of Dea	th 2005	2 Time (Death R
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သွ	aw 2 sb	Completed						24a. Was a autops	an 24b. Were au	itopsy findings available completion of cause of
	The le h age	mo:						perfor	med? death?	2 No
Vital	ysician: Is certifical	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only or		
\	ys dii	To	1 ☐ Yes 2 ⊠ No	Hospital: 1 Inpatien	t 2 ER/Outpation	ent 3 DOA Oth	er: 4 🗌 Nursing H	lome 5 ☐ Reside	ence 6 Other (Spe	city)
n of	ng Pt fter th		27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	of 28c. Injury Work	y at k?	28d. Describe h	ow injury occurred	
Sio	Attanding r death. actor: After by the fune	catl	2 Accident investigatio			M 1 🗆	Yes 2 □No			
Division	of or Attand after death Diractor: /	Certification:	3 Suicide 6 Could not be determined		y - A t home, farm, s <i>(Specify)</i>	treet, factory, office		28f. Location (S. City or Town	treet and Number or Ru n, State)	ural Route Number,
	ital c			1						
	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical	(Check only 2 Medical Exal	nysician: To the best of miner: On the basis of e	examination and/or i	th occurred at the tin evestigation, in my o	ne, date and place pinion, death occu	a, and due to the curred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To tha be within 24 To tha formplet	Med	29b. Signature and title of certifier	and manner state	BQ.	29c. License	e number	1 2	29d. Date signed (Mont	h Day Year)
	To To		1//////////////////////////////////////	10/00)			ļ.		**
7			1 hand	mulling	oth (Hom Ode) (Time	Dailer)	20000	†	June of.	, 4003
			30. Name and address of person who Mark Malkus		ath (Item 23a) (Type	- Stroot	(1.1	-0.	June 23. Varyland	21613
	Sta	te	31. Date filed (Month, Day, Year)	32. Re Etrar	's Signature	D : 4	umb	. oge, N	iniyiand	0141)
2	Registr		JUN 27	7000	and the	Garly.				

			St.				Health and	•	_	ible.	
			1 - For State Registrar			rtificate of			g. No 2 N	05	22000
	Divi-i		Decedent's Name (First, Middle, Last)					2. Date of Deat Month		Year	3. Time of Death
	Physici /Medic			all		_			21 2	005	10:50p ^M
	Examin	ner	4a. Facility Name (If not institution, give street	and number)			or Location of Deat	h		y of Death	
	F		1101 Race Street 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		ridge	8. Date of Birth		rches	
	Funeral Director		214-07-8024		91 Yrs.	Months Day	s Hours Min.				place (State or Foreign ntry) ryland
70	2 > 7		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or Lo				-1213		
7	ed at	ō	MD Dorcheste:		oc. ony, rown or co		oridge				10d. Inside City Limits 1 Yes 2 □ No
) at the response	288-	Director	10e. Street and Number	_		10f. Zip Code		16	og. Citizen of	What Cour	ntry?
) =	3a or		1101 Race St.				21613			USA	
	eme 3	Funeral	11. Marital Status 12. V	/as Decedent Ever	er in U.S. 13.	Was Decedent of	Hispanic Origin? (S	pecify Yes or No-	14. Ra	ce - Americack, White,	
9	or It	by Fu	1 Never Married 2 Married 1	☐ Yes 2 No Yes, Give ear or Dates:		1 ☐ Yes 2 🛣 N			Speci		ite
IZIS-0036	ing within 72 from a and been with the way at tal Hygiene. Id Hygiene. In Hygiene. In Medical Examiner must be notilied at event, the Medical Examiner must be notilied at		15. Decedent's Education		16a, Dece	dent's Usual Occ	unation	1.	16b. Kind of E	*****	
ר אַ אַ מּ	Medition.	Completed	(Specify only highest grade con	ollege (1-4or 5+)	(Give	kind of work don DO NOT use retir	e during most of wo	rking	TOD. THING OF E	20011003411	dustry
N 3	giene or tha	Com	11			taxider	mist		taxide	ermy	
_ (ital Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M	faiden Suma	me)	
	and Mental Hygiene. Is marked other than aumatic event, Ina Mg	70	Elmer Hall	laine)	405 44400			Phillips			0.11
Z S	permit rages I and Should be perment of Health and Menta Importent: If Item 27 is marked eny Injury or other traumetic evonce.		19a. Informant's Name/Relationship (Type, F William F. Hall				et and Number or Ru				
6 , 5	f Heal		20a. Method of Disposition	son	20b. Place of Dispo cemetery, crei	sition (Name of	Creek Rd.	Date 2	20c. Location	2164. • City or To	
oe a	nent o int: If iry or		1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	Valificili State	Green Law		· · · · · · · · · · · · · · · · · · ·	4/05	Cambr:	arbi	MD
Baltimor	Depertu Depertu Importe eny Inju		21. Signature of Funeral Price Licensee				ress of Facility T				
D 2	20599		the Herr				st St., C			21613	
			23a. Paid. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused th use on each line.				or respiratory arre	st,		Approximate Interval Between Onset and Death
	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)			n Co	hucer				
	xaminer		ſ	Due to (or as a o	consequence of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a c	consequence of):						*
rou,	ysician and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	D 1 1 1 1							
/ 5U,	ician a	cai E		Due to (or as a c	consequence or):						
	phys s the	edic	d								
X S	anding use a	n/M		yes, outcome of		76			23d. Da	ate of delive	ery
ם פֿ	ne ette ed for	sicla	1 Yes 2 No	☐Live birth 2 [☐Pregnant at tin ☐ Unknown		□Ectopic pregnan □ Other (specify)	cy		М	onth	Day Year
7. §	d by the	Physician/M	9 🗆 Unknown		and an extension to the con-	-46.	and Book	One Didash			and the same
ords,	mequies manue describerminate been signed by the ettending phys should be detached for use as the	b	Part II. Other significant conditions contribu	ting to death but i	not resulting in the u	nderlying cause g	iven in Part I.	239. Did tob	~		ne cause of death?
cords,	peen	Completed						24a. Was ar			psy findings available
The law	2 5	mo						autopsy perform	/	prior to con death?	inpletion of cause of
	certificate rector, pag	0	25. Was case referred to medical	· · · · · · · · · · · · · · · · · · ·			26. Place of Dea	1 ☐ Yes 2		1 Yes	2)Q No
- Q	this certificate ha	To B	examiner? 1 Yes 2 No Hospit	al: 1 Inpatient	2 ER/Outpatier	nt 3 DOA		lome 5 Reside	-	her (Specif	γ)
			27. Manger of Death 1 Natural 5 Pending	a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	W	ork?	28d. Describe ho	w injury occu	rred	
UIVISION	death.	icati	2 Accident investigation 3 Suicide 6 Could not be	la Diago of Isings	At home form etc		_Yes 2 □No	28f. Location (Str	not and Mum	hor or Dur	I Pouto Alumbas
VIO S	after Direct Jin by	Certification:	4 Homicide determined	building, etc. (- At home, farm, str (Specify)	еет, тастоту, оптс	3	City or Town		Der or Hura	i noute Number,
_ efficach	within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely filled in the funeral complete	cai	29a. Certifier (Check only one) (Check only one)	On the basis of ex	camination and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occu	, and due to the ca irred at the time, da	use(s) and m te and place,	anner as s	tated. the cause(s)
d d	vithin; of the	Medi	29b. Signature and title of certifier	and manner state	Δ.	29c. Licer	nse number	29	d. Date signe	ed (Month,	Day, Year)
۲	- s - 0		> Jamesure	MD		D	17924	6	5.23	05	
			30. Name and address of person who imple		th (Item 23a) (Type,	Print)					16 -
			NOMIAN THANKY	300	AURUR	A STR	eet car	ABRIDGE	17	02	16/3
	Sta Registr		31. Date filed (Month, Dukrar 2 4 20)	32. Registrar's	s signature	done					:

Physicia		1. Decedent's Name (First, Middle, Last) William Dixon Hepp	erle, Jr.	Certificate of	Dodui	2. Date of Death Month June 27	Day Year	23. Januar 12. 20 PM
/Medic Examin	7	4a. Facility Name (If not institution, give s		4b. City, Town, o	or Location of Death		4c. County of Dea	
-Admin	••	Genesis HealthC	are - The Pir	Ea	aston		Tal	lbot
uneral irector		5. Social Security Number 6. Sex 11. 11.	7. Age (In yrs. last bi		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Oct. 26,1	9. Bir 927 Pen	thplace <i>(State or Foreigi</i> ountry) nsylvania
M T		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Location				10d. Inside City Limits
fieds	to	Maryland Caroline	Prest	on				1 □ Yes 🏋 No
or 288	irec	10e. Street and Number		10f. Zip Code	-	10g.	Citizen of What C	ountry?
23a ust b	la	21182 Marsh Creek	Road, #49	21655			US.	A
Itams	Funeral Director		2. Was Decedent Ever in U.S. Armed Forces? 1945	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
ural', or	þ	1 Never Married 2 Married 3 Widowed 4 XDivorced	If Yes, Give Year or Dates: 1947	1 ☐ Yes 2 🛣 No				nite
itan 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avent. The Medical Exemple rules be multiped at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of work d)	ring	. Kind of Business	
her t		10 17. Father's Name (First, Middle, Last)	Tr	uck Driver	18 Mother's Nam	Ma ne (First, Middle, Maid	nufactur	ing
ed of) Be	William Dixon Hepp	erle. Sr.			ae Hubley	Jen Sumame)	
mark	2	19a. Informant's Name/Relationship (Typ		b. Mailing Address (Street			ty or Town, State,	Zip Code)
27 is r trau		Sharon D. Davis/Da	ughter 1	421 Maryland	l Avenue,	Severn, M	D 21144	
itam		20a. Method of Disposition	20b. Place o	of Disposition (Name of ary, crematory or other pla			. Location - City or	Town, State
ant: If		1 ☐ Burial 2 🖫 Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	miovai iruni State I	ry of Delmarv		/2005 De	1mar, De	laware
Important: If itam 27 any injury or othar tr		21. Signatury of Puneral Service Liberale	Beller	Zeller Fur 106 Main S	ess of Facility neral Home Street, Ea	e, P. O. B ast New Ma	ox 207 rket, MD	21631
To the Function of the functio	edical Examiner	cea. Pagh. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last	Нурохіа	reart failu neart failu				Approximate Interval Between Onset and Death Would Months
by the attending ached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	livery Day Year
as been signed by the 2 should be detached	þ	Part II. Other significant conditions con	inbuting to death but not resulting		ven in Part I.	23e. Did tobaca	./	o the cause of death?
ite has beer bage 2 shou	Completed					24a. Was an autopsy performed	prior to death?	utopsy findings availab completion of cause of
ctor.	Be C	25. Was case referred to medical examiner?				th (Check only one)		
After this certificate ha	P.	1 Yes 2 No	28a. Date of Injury 28b.	utpatient 3 DOA Oth	ry at	ome 5 Residence		ocify)
actor: Aft by the fur	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f	M 1	Yes 2 □ No	28f. Location (Stree		ural Route Number,
To tha Funeral Dira completely filled in b		4 Hornicius	building, etc. (Specify)	on double and as the si	no data and since	City or Town, S.		
a Fun etely	edical	(Check only 2 Medical Examin	ician: To the best of my knowledger: On the basis of examination a and manner stated.	nd/or investigation, in my	me, date and place, opinion, death occur	red at the time, date	and place, and du	s stated. e to the cause(s)
To th compl	Me	29b. Signature and title of certifier	Dy mo	29c. Licens	se number	29d.	Date signed (Mont	1
111		1 /XINC	mpleted cause of death (Item 23a)		4371		02016	1/

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

William Hepperle

			_ For	State of Ma	arylan	d / Depa	rtment of F	lealth :	and Mental H	ygiene	3.0.00	
		_	1 - State Registrar			Cer	tificate of	Death		Reg. No2	005 2	3101
	Physicia	_	Decedent's Name (First, Middle)	J. Jone					2. Date of I Month 6 6	Death Day	Year 3	Time of Death
	/Medic Examin		4a. Facility Name (If not institution,) 		4b. City, Town, o	r Location			nty of Death	<u> </u>
			University of	Maryland	Med-	Cuter		more		Ba	Himore	City
	Funeral Director		5. Social Security Number 217–36–2351	6. Sex 7. Age 1	in yrs. 1. 65	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. 8. Date of E	5, 1940	9. Birthplace Country) MARYLA	(State or Foreign
	D		Usual Residence of Decedent 10a, State 10b, County		10c Cib	, Town or Lo	nation					
	Maryla f ehov	ō	MARYLAND CAROLI	NE		ENSBOR						Inside City Limits 1 ☐ Yes 2 X No
	th the	lrec	10e. Street and Number		GIG	ширрог	10f. Zip Code			10g. Citizen	of What Country?	
	s 23a	rai	12141 GREENSBOR				21639				D STATES	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 ie marked other then "naturel", or Items 23a or 28a-f ehow or other traumetic event, Ite Medical Exactinal must be notilied at	y Funerai Directo	11. Marital Status 1 Never Married 2 Married	If Yes, Give		1	Vas Decedent of F FYes, specify Cubi □ Yes 2 No	lispanic Or an, Mexicai Specify:	igin? (Specify Yes or I n, Puerto Rican, etc.) :	E	Race - American I Black, White, etc. I ^{cify:} WHITE	ndian,
21215-0036	2 hours	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent	Year or Dates:	1968	16a. Deced	lent's Usual Occup	ation			MHIIE f Business/Indust	rv
215	within 72 ene. then "na	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4or 5	+)	(Give life. L	kind of work done OO NOT use retired	during mos d)	st of working			,
	iled wi lygien her th nt, the		12 17. Father's Name (First, Middle, I	acti		OWNER	/OPERATO		er's Name (First, Midd		COLLECT	'ION
and	ld be f ental h ked of	To Be	GEORGE ANDREW J						EL THOMAS	ie, ivialderi Suri	iaine)	
Maryland	2 shou and M ie mar aumeti	-	19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street		er or Rural Route Nun	ber, City or Tox	wn, State, Zip Coo	de)
	1 and 1 Health sm 27	1	BARBARA JONES 20a. Method of Disposition	(WIFE)	20h Pi		GREENSB sition (Name of	ORO R	OAD GREEN	_	MD 21639 on - City or Town,	
nor	Pages nent of } int: If ite		1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (Sp		CE	metery, cren	NS CEMET	TDV	/01/2005		CK, MARY	
Baltimore,	permit. Pag Department Importent: Il any injury o		21. Signature of Funeral Service L		4	FF	. Name and Addre	ss of Facili	BEIN AND N	EWNAM F	UNERAL E	
	403 60		23a. Part1. Enter the disease, or	complications that caused	the death				AD CHESTER cardiac or respiratory	_	Ap	proximate
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition		i	axcul	or As	e ed	4- +		On	erval Between iset and Death
	/Medical Examiner	-	resulting in death)	Due to (or as								
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as:	2 A a consequ	ience of):						
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c								
60,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a consequ	ience of):						
68760,	ficate I physics the t	edica		d								
Box	death certificate be executed e attending physician and d for use as the burial-transi	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy	,			Date of delivery	
O. E		hysician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown			Other (specify)				Month Day	y Year
S, D	requires that the een signed by th nould be detache	by PI	Part II. Other significant conditio	ns contributing to death be	ut not resu				I. 23e. Di	d tobacco use c	ontribute to the ca	ause of death?
of Vital Record	v requir been si should l	eted	10 tractable	Vesty icu	ac	190	Mycacd	19]Yes 2□No		
Rec	e lav has	Completed								topsy formed?	prior to comple death?	findings available etion of cause of
ta		0	25. Was case referred to medical					26. Place	1 Yes e of Death (Check onl		1 ☐ Yes 2 🔼	No
) \	Physicien: r this certificatal director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital:		ER/Outpatien		4 🗀 140	ursing Home 5 🗆 Re			
ono	ding h. After fune	tlon:	27. Manner of Death 1 X Natural 5 Pending 2 Accident investig		y Year)	28b. Time of Injury	28c. Injur Wor M 1 □			e how injury occ	curred	
Division	i or Attending after death. Director: After i in by the fune	ertification;	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	not be 390 Place of Init	ury - At ho c. (Specify	me, farm, str			28f. Location	(Street and Nu own, State)	mber or Rural Ro	ute Number,
	purs ours erel	O	29a. Certifier 1 Certifyin	g Physician: To the best of Examiner: On the basis of	of my know	wledge, death	occurred at the tir	ne, date ar	nd place, and due to the	e cause(s) and	manner as stated	i.
	To the Hos within 24 h To the Fun completely	Medical	one) 29b. Signature and title of certifier	and manner sta	ited.	ion and/or in	29c. Licens		aur occurred at the tim		ned (Month, Day,	
)	F 3 F 8		1 Kin	tion Ul	loa				435	061	1 1	2005
_			30. Name and address of person (who completed cause of d	eath (Item	23a) (Type.	Print) West S	Stream	+- Balt	inore	M 1) 2	1230
47	Sta Registr		31. Date filed (Month, Day, Year)	- 1 2005 Regis	ar's Signal	ture #	Jarle		t. Ball			

JET 05-04433 Robert Jackson

ber	t Jacks	on	State of Maryland / L State of Maryland / L State of Maryland / L State of Maryland / L Registrar		ental Hy	giene
	* R to		Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Dea	
	Physici	an	Robert Alan Jackson		Month	Day Year
100	/Medic			4h Cih. Tour er legation of Death	July	1 2005 7:15 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		
~			216 Poplar Ave 5. Social Security Number 6. Sex 7. Age (In yrs. last birt)	Ferndale Hoday If Under 1 Year If Under 24 Hrs.	8. Date of Birt	Anne Arunde1 9. Birthplace (State or Foreign
200	Funeral Director			Yrs. Months Days Hours Min.	July 24	9. Birthplace (State or Foreign Country) New York
• ,	death with the Maryland ma 23a or 28e-f ehow rmat to notified at	tor	10a. State 10b. County 10c. City, Town Maryland Anne Arundel Glen Bu			10d. Inside City Limits 1 □ Yes 2★ No
	th the	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
	23a		216 Poplar Ave.	21061		United States
920	after or its	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No 1974— If Yes, Give Year or Dates: 1975	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Ö	72 hours "naturel",	Completed	15. Decedent's Education 16a.	Decedent's Usual Occupation (Give kind of work done during most of workir		16b. Kind of Business/Industry
21	thin 7	od l	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	ig .	
21	ed wii	Con	12 Fir	re Fighter		Prince George's Co.
land		To Be (17. Father's Name (First, Middle, Last) Robert D. Jackson	18. Mother's Name Eileen L		
Maryland 21215-0036	s 1 and 2 should f Health and Men itam 27 ie marke other treumatic			Mailing Address (Street and Number or Rura. 2926 Parran Dr., Lusb		
Baltimore,	permit. Pages 1 and 2: Depertment of Health at Importent: If item 27 ie eny injury or other treu		Cemeter Communication Communic	Disposition (Name of y, crematory or other place) eterans Cemetery 7/06	/05	20c. Location - City or Town, State Cheltenham, Maryland
Balti	permit. Depertm importe eny inju		21. Signature of Funeral Service Licenses MOO542	22. Name and Address of Facility Rau	sch Fur	neral Home, P.A. Port Republic, MD 20676
1.			23a. Part1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.			
	Physician		Immediate Course (Final			Onset and Death
1	/Medical		disease or condition resulting in death) The properties of the state	herosclerotic Cardiov	ascura	r Disease
	Examiner					
	rted I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	of):		
,092	ate be executed sysicien and he burial-transit	cal Exa	resulting in death) Last C. Due to (or as a consequence of	of):		
687	phys phys s the		d			
Вох	Attending Physician: The law requires thet the death certificate ordath. •ctor: After this certificete hes been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ر. ح.	is thet t pred by e detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did to	obacco use contribute to the cause of death?
ord	w requires that the dibean signed by the should be detached	eted t			10	Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O.	ician: The law certificete hes t rector, page 2 s	Completed			24a. Was autor perfo 1 Yes	osy prior to completion of cause of death?
₹	certil	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death		
n of	ding Phys h. After this funeral di	on: To	27. Manner of Death 28a. Date of Injury 28b. 1	tpatient 30 DOA 40 Indising Hon		dence 6 Other (Specify) how injury occurred
sio	uttendi death. ctor: A y the fu	cat	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Divi	ē. <u>Ģ</u> # ē	Certification:	4 Homicide determined 288. Place of Injury - At nome, 1a building, etc. (Specify)		City or Tov	
	Hospitel 24 hours (Funerei etely filled	Medical	29a. Certifier 1☐ Certifying Physician: To the best of my knowledge (Check or by one) 2 M Medical Examiner. On the basis of examination an and manner stated.	, death occurred at the time, date and place, a coor investigation, in my opinion, death occurre	and due to the ed at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		52	Yanat Douthall.MI)	OCME		July 2 2005
			30. Name and address of person who completed cause of death (Item 23a) Planck E. Southul, M.	(Type, Print) 111 Penn Street	Baltim	ore, Maryland 21201
23/2	Sta Regist			H. Sports		
30	er 3,	100	JUL 0 1 LOUD JULE	Control of the Contro		

			110030	State of Maryla				-	niene	7.		
			1 - For State Registrar	Otate of Maryta		ertificate		i wichtar riy	Reg. No.2 0 0	5 23103		
			Decedent's Name (First, Middle, La	st)		- Invocato	0. Dod.,,	2. Date of Dea	ath	3. Time of Death		
	Physici		Grady C.	Jenkins	Jr			June 2	27, 2005			
	/Medic Examin		4a. Facility Name (If not institution, give				vn, or Location of De		4c. County of D			
			2285 Cove Poi	nt Road			Lusby		Cal	vert		
	Funeral		5. Social Security Number 6. S	6ex 7. Age (In yrs y□ M 2□ F 74	. last birthday Yrs.		ear If Under 24 H		h 9. 1	Birthplace (State or Foreign		
	Director		240–40–5076 Usual Residence of Decedent	74	115.			August	1930 100	Lui Carollina		
	/land	by Funeral Director	10a. State 10b. County		ity, Town or I	_ocation				10d. Inside City Limits		
	Man,		Maryland Calvert		Lusby					1 ☐ Yes 2 ☐ ¥No		
	or 284		10e. Street and Number	,		10f. Zip Co	de		10g. Citizen of What	Country?		
	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-1 show ha Mazigal Exanti armusi Le ricilifiad at		2285 Cove Point Road			2065	7		United Sta	tes		
	er de	nue	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13	. Was Decedent If Yes, specify	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.		
36	rs aft	oy F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ZYes 2 □ No If Yes, Give Year or Dates: 49–5	3	1 ☐ Yes 2 ☐ Mo Specify:			Speciahi	te		
21215-0036	2 hou	ted	15. Decedent's E	ducation	16a Dec	Sa. Decedent's Usual Occupation			16b. Kind of Busine	ss/Industry		
215	hin 7. 9. Medi	pie	(Specify only highest gr	ade completed) College (1-4or 5+)			one during most of we etired)	rorking				
7	ygieni Agieni Ar th	To Be Completed		1	engin	ær techn	ician		U.S. Navy			
nd	be filk ital Hy id oth evani		17. Father's Name (First, Middle, Last Grady C. Jenkins, Sr.)				8. Mother's Name (First, Middle, Maiden Surname) Vancy Baker				
ryla	d Men narka natic	T ₀	-	The Reine	405 44-1				- O: - T - O: -	7: 0 11		
Maryland	d2st than thaur traun		19a. Informant's Name/Relationship Barbara C. Jenkins –						or, City or Town, State	e, Zip Code)		
ē,	Heal Heal tam 2		20a. Method of Disposition	20b.	Place of Dist	nosition (Name	t Rd. Lusby,	Date	20c. Location - City	or Town, State		
JOH	ages ent of nt; If i		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		ng Creel	ematory or othe k Memoria	r place) July 2 1 Cenetery	2 2005	allas North	Carolina		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or itams 23a or 28a-f show any injury or othar traumatic evant, the Medical Ergering India Legical and Once.		21. Signature of Funeral Service Lice		- 1	22. Name and A	ddress of Facility	Rausch Fune	eral Home			
m	Depa Impo any ir		5t5.5th		44	05 Broome			olic Marylan	20676		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the dea						Approximate Interval Between		
	Physician	8 19	Immediate Cause (Final disease or condition	a CHRONIC	0357	RUCTIVE	PULMON	ARY DI	SEASE	Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a consequence of): b. Due to (or as a consequence of):								
		-	Sequentially list conditions,									
Т	nted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
Ć,	exection and ial-tre	Еха	that initiated events resulting in death) Last Due to (or as a consequence of):									
8760,	death certificate be executed e attending physician and of for use as the burial-transit	cai		_ d						_		
9	ntifica ng ph a as th	Med	IF FEMALE:				-		1			
Вох	death certifica attending ph d for use as tl	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregi 1☐Live birth 2☐Fe	re birth 2 Fetal death 3 Ectopic pregnancy					delivery Day Year		
0.		/sici	1 Yes 2 No	4 □ Pregnant at time of death 5 □ Other (specify)				WORTH	Month Day Year			
<u>α</u>	The law requires that the di ite has been signed by the bage 2 should be detached				Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying caus	e given in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
Records,	signed of be de	d by								1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
00	w requir been si should	Completed	LUNG CANCER, HYPERTONSION. 10Hes SLEEP ARIEA 24a. Was an autonomy.							24b. Were autopsy findings available		
Re	The lav	dmc	300-					- autop perfo	prior med? death	to completion of cause of		
Vital		0	25. Was case referred to medical	26. Place of Death (Ch					1 Yes 2 No 1 Yes 2 No			
Ž	ysicl Is cer direc	Fo B	examiner? 1 Tes 2 No						ome 5 ☐ Residence 6 ☐ Other (Specify)			
n of	19	ertification: T	27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28a. Date of Injury (Month, Day Year) 28b. Time of 19 28c. Injury at 28d. Work?				28d. Describe how injury occurred			
Sio	E at		2 ☐ Accident investigation	n M 1 Yes 2 No								
Division	il or Attandir after death. Diractor: Af d in by the fu	rtiff	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						ion (Street and Number or Rural Route Number, r Town, State)			
	To tha Hospital or Atte within 24 hours after de To tha Funaral Diracto completely filled in by the	O	29a. Certifier 1 Certifying P	hysicien: To the best of my kr	nowledge de	ath occurred at t	he time, date and old	ce, and due to the	rauso(s) and man-	as etated		
	24 hos Eun	edicai	(Check only 2 Medical Exa	miner: On the basis of examir and manner stated.	nation and/or	investigation, in	my opinion, death oc	curred at the time,	date and place, and	due to the cause(s)		
	To th. Vithin To the	Me	29b. Signature and title of certifier	2 0		29c. L	icense number		29d. Date signed (Me	onth, Day, Year)		
			I / th H.	Weest m		Do	26358		JUNE 20	P 2005		
			30. Name and address of person who	completed cause of death (Ite	em 23a) (Typ	e, Print)	F 63 1					
J	4+1		J-WEI	GEL, MJ-		RINCE	+ RESI	FRICK	(1)-	20678		
	Sta Regist		31. Date filed (Month, Day, Year)	completed cause of death (Ite	nature A	Spare	()					

			Please Type or Print in Black Indel State of Maryland / Departm 1- State Registrar Certific	•	•			
İ	Physici /Medio	al	Decedent's Name (First, Middle, Last) Elizabeth Evelyn Kelley 4a. Facility Name (If not institution, give street and number) 4b.	Monti	of Death Day Year e 30, 2005	J. JJ AM		
	Funeral	ier	38710 Collinwood Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Abell Under 1 Year If Under 24 Hrs. 8. Date of the normal state of	Saint M of Birth h, Day, Year) 9. Bi	larys inthplace (State or Foreign Country)		
Baltimore, Maryland 21215-0036	Director	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		ary 4, 1929 Dist	10d. Inside City Limits 1 □ Yes 2 ☑ No		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examination is notified at Ances.	by Funeral Director	10e. Street and Number 38710 Collinwood Drive 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was I	20606 Decedent of Hispanic Origin? (Specify Yes specify Cuban, Mexican, Puerto Rican, etc.)	10g. Citizen of What C USA or No- 14. Race - Am Black, Wh	nerican Indian,		
	72 hours after "natural", or it	eted by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's (Give kind)	Yes 2 No Specify: Usual Occupation of work done during most of working	Specify: Wh	ite		
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygione. Importent: if item 27 is marked other than 'any injury or other treumatic event, If a Mange.	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemak 17. Father's Name (First, Middle, Last)	er 18. Mother's Name (First, M	OWn Home			
	and 2 should salth and Men n 27 te marke ter treumatic	To	John H. Russell / Son 38888 Cha	Lilly Morgan Idress (Street and Number or Rural Route Natico Road, Mechanicsvil)		. ,		
	permit. Pages 1 Department of He Importent: if iter any injury or oth		20a. Method of Disposition 1 \(\times \) Burial 2 \(\times \) Cremation 3 \(\times \) Removal from State 4 \(\times \) Donation 5 \(\times \) Other (Specify) 21. Signature of Funeral Synice (Icensee) 20b. Place of Disposition cemetary, cremator, St. Joseph's (22. Nar.)	y or other place) Cemetery July 6, 200 me and Address of Facility				
ä	- 1	10	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.		ryland 20650 ory arrest,	Approximate Interval Between Onset and Death		
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) a. Castuc Cancinoma Guerral Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of):					
68760,	ficate be executed g physicien and is the burial-transit	ā	that initiated events resulting in death) Last c. Due to (or as a consequence of):	81001		1113		
P.O. Box 6	The law requires that the death certificate to has been signed by the attending physogge 2 should be detached for use as the	by Physician/Medic		opic pregnancy er (specify)	23d. Date of de Month	elivery Day Year		
Records, P	requires een sign nould be		Part II. Other significant conditions contributing to death but not resulting in the under			Probably 4 Unknown		
Vital Rec		Be Completed	25. Was case referred to medical examiner?	1 ☐ \	autopsy prior to death? Yes 2 No 1 □ Ye			
o	utending Physician: death. ctor: After this certific y the funeral director, y	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 1	28c. Injury at Work? 28d. Desc	esidence 6 Other (Sp cribe how injury occurred	ecify)		
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	cal Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, full building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	City of	tion (Street and Number or For Town, State)	as stated		
)	To the Hi within 24 To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated. 29b. Signature and title of certifier	gation, in my opinion, death occurred at the	29d. Date signed (Mor			
<			30. Name and address of rison who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 22. Registrar's Signature	of Loohad Ld	Leonard F	sen MD		
DV	St Regist	100	JUL 0 5 2005	,				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1 5 3. Time of Carlo 1. Decedent's Name (First, Middle, Last) Richard Paul Karlowa 2. Date of Death Month June 28, 2005 ar 12:00 P.M. **Physician** /Medical Beverly Health Care 4b. City, Town, or Location of Death Hagerstown Washington Examiner If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Iovauntry) **Funeral** 5 Social Security Number 213-22-3489 1**⊠** M 2□ F Months Days Hours Min. Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydrene. Importent: If Item 27 is marked other than "neture!", or Items 23e or 28a-f show any Injury or other freumetic event, the Medical Examiner must be notified at page. 10a. State Maryland 10c. City, Town or Location Cumberland 10d. Inside City Limits Allegany 1 Yes 2 No Director 10e. Street and Number Baltimore Street 10g. Citizen of What Country? U.S.A. 10f. Zip Code 21502-Apt. 516 Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 1 54-54
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Married 2 Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Completed by Specifie White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eldontary/Secondary (0-12) 2 College (1-4or 5+) finance company 7. Father's Name (First, Middle, Last)
Robert K. Karlowa 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna Marie Walters Robert Schellhaus nephew 2127 Sile and Day Steet and Number or Rural Route Number, City or Town, State, Zip Code)
Morgantown
26508 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State St. Michaels Parish Cemetery 01-Jul-2005 Frostburg 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland `4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 olle 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 No funeral director, page 2 should Be Completed peen 24a. Was an autopsy performed? 1 ☐ Yes 2 ⚠ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending Injury 1 Tes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated 29b. Signature and title of dertifie 29c. License number 29d. Date signed (Month, Day, Year) D0062327 8/1UA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 368 MAGERIOWN DR. R. BAMS AL MILL 31. Date filed (Month, Day, Year)
JUN 3 0 2005 32. Raistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** William Homard Keetley, Sr. 1615 29 2005 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Residence: 80 South Main Street Port Deposit Cecil 8. Date of Birth
(Month, Day, Year)
Feb. 18, 1914 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 X M 2 ☐ F 177-10-9562 91 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rthan "natural", or items 23a or 28a-f ahow the Woolcal Examiner must be notified at 1X Yes 2 No Director Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 80 South Main Street 21904 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Keetley Motor Company other than Elementary/Secondary (0-12) College (1-4or 5+) Port Deposit, Maryland Eleven Years Owner/Operator permit Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William T. Keetley Elizabeth Sinclair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth W. Keetley (son) 701 South Washington St., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Angel Hill Cemetery 07/02/05 Havre de Grace, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Licensee Thoras N. + THEEDON, Or. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** V2 DWVA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-Physician/Medical as the attending IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 cate has been sig., page 2 should b 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has autopsy perform 1 ☐ Yes 2 2 110 Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours after To the Funeral Dire ō pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed pause of death (Item 23a) (Type, Print) Gny 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

JUL - 1 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

		1	For State Registrar	State of Maryland		rtment of H tificate of L			ene PNS	23107
	ıysicia	n	1. Decedent's Name (First, Middle, Last) George Willi	am Klein,	Sr.			2. Date of Death Month June 27	Day Year 2005	3. Time of Beath
/Med Exam	Medic camin		4a. Facility Name (If not institution, give s		DI.	4b. City, Town, or	Location of Death	buile 27	4c. County of Deat	
Fun	neral		3821 26th Stree 5. Social Security Number 6. Sex	7. Age (In yrs. lasi	t birthday)	If Under 1 Year	ke Beach	8. Date of Birth	Calvert 9. Birt	hplace (State or Foreign
	ector		218-16-0448 ¹☒ Usual Residence of Decedent	M 2□F 77	Yrs.	Months Days	Hours Min.	(Month, Day, Y) Feb. 4,		yland
ryland	3		10a. State 10b. County	10c. City, 1	Town or Loc	cation				10d. Inside City Limits
deeth with the Maryland ms 23a or 28a-f show	ciffic	Director	MD Calver	t Che	esape	ake Beach	1	100	. Citizen of What Co	Yes 2 No
h with	atte		3821 26th Street	Ł		20732)	109	U.S.A.	outry:
	- B	by Funeral	1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1946—		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No		ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
TZIS-UU36 within 72 hours after ane. than "netural", or Ite	event, the Madical Ex	Completed b	3X Widowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	eation completed)	16a. Deced	ent's Usual Occupa kind of work done o OO NOT use retired	furing most of work	ing 16	b. Kind of Business	
N 855	17.6	Com	7	College (1-4or 5+)	carpe	nter / wa	iterman		elf emplo	yed
land Id be fill ental Hy ked off		To Be	17. Father's Name (First, Middle, Last) Harry Joseph	Klein			18. Mother's Nam	e (First, Middle, Ma Mae Bu	ckmaster	
Warylan d 2 should be th and Mental 17 Is marked	aumat	 	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailin	g Address (Street a			City or Town, State, 2	Zip Code)
deal deal	2		Catherine M. King 20a. Method of Disposition		3562 a of Dispos	7th St., sition (Name of patory or other place	North B	each, MD	20714 c. Location - City or	Town, State
Saltimore, bermit. Pages 1 ar Department of Hea moortant: If item	ury or		1 \(\overline{\begin{align*} \text{Specify} \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			cial Gard		0/05 D	unkirk, M)
bermit. Pages : Department of H	any in		21. Signature of Funeral Service License	Andread		Name and Addres	·	- D.A	0.1	00726
			23a. Part1. Enter the disease, or complice shock, or hear failure. List only on	cation that caused the death.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arrest	Owings, M	Approximate Interval Between
Physic /Med	ician dical		Immediate Cause (Final disease or condition resulting in death)	non sr	nal	Cell	lune	cano	er	Onset and Death
Exam			Securitially list conditions b	Due to (or as a consequer	nce or):		/			
per	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
8 / 6U, ate be executed	the burial-transit									
68/60 ificate be e	s the b	edicai	d	•						
Box 6 death certific	detached for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
Ords, P.O. requires that the	be detach	y Phy	9 ☐ Unknown Part II. Other significant conditions con	tributing to death but not resulti	ng in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
COLDS W requires been sign	should be	ted by						1 🗆 Yes	2 No 3€Pr	obably 4 Unknown
I KeC The law ate has b	9 2	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
OT VITAL P Physiclen: Th	· =	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatien	t 3□ DOA Othe	25	h (Check only one)	e 6 DOther (Sne	cifu)
Afte	funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1	Bb. Time of Injury	IL 3C DOX 4C RUISING HOME DAT RESIDER				
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After	ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined		City or Tow		City or Town,	Street and Number or Rural Route Number, wn, State)		
a Hospi 24 hou	etely fil	edical	29a. Certifier Certifying Physical (Check only one) Certifying Physical Examination Certifying Physical Examination Certifying Physical Examination Certifier Ce	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the timestigation, in my op-	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
To the within	сошь	Me	29b. Signature and title of certifier	1)		29c. License	number	290	I. Date signed (Monta	h, Day, Year)
		1	20.00	Apleted cause of death (the C	20) //	D S	55165		5-290	25
10			Jonathan W. ox	pleted cause of death (Item 2	D. 11	D NOSP	stal Ros	od Ste 31	U, TRINCE +	REd., MI)
R	Sta egistr		31. Date filed (Month, Day, Year) JUN 2 S	32. Registrats Signatur	K	back		/	1	/

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 0250 LaGratta 07 05 Geneva Marie 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Heart Hospital Examiner Allegany Cumberland Sacred If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 7, 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Yrs. ΜĎ 213-24-6125 Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, It is Medical Examiner must be notified at MD Allegany Cumberland Completed by Funeral Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 5 133 West Third Street 21502 items 23a USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filled within 72 hours after on and Mental Hygiene. Is marked other then "natural", or iter 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify. 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Mason's Barn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Denver Ketterman Delphia (Kisamore) Ketterman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 is i ury or other traus Fred Timbrook 119 S. Lakewood Drive Ridgeley WV 26753 son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State pernit. Page Department of Important: if any injury or once. Sunset Memorial Park 7/13/2005 Cumberland MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Sign wure of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician ACUTE RENAL FAILURE /Medical Due to (or as a consequence of): Examiner RENAL FAILURE FILE VENTA CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed BRONCHITIS page 2 should 24a. Was an autopsy performed? 1 ☐ Yes 2 🔼 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes of Vital funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division Injury 1 Natural 5 Pending after death. Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ni bellif 24 hours a Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Functional 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JULY 11, 033417 /MARELMO 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 JAMES R. MUEN MO 1068 NATIONAL HIGHWAY LAVALE, MANTLAND 31. Date filed (Month, Day, Year) 2. Registrar's Signature 1 4 2005 Registrar

/Medi	ian cal	1. Decedent's Name (First, Middle, Las Sanaii J. Leonard Sanaii L. Leonard							2. Date of Dea		2005	6:43A.
Examir	ner	4a. Facility Name (If not institution, give PENINSULA REGIONAL	L MEDICAL C		SA	ty, Town, or ALISBU	RY			WI	COMICO	
Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 1 Security Number 2 Security Number 1 Security Number 1 Security Number 1 Security Number 2	ox 7. Age (□ M 2 □ XF 1	(In yrs. last bii	Yrs. Month	der 1 Year ns Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da ept 9,	v. Year)	9. Bir	thplace (State or Fore ountry) MD
-f ehow	tor	10a. State 10b. County MD Wicomi		10c. City, Tow Salish			-					10d. Inside City Lim TX Yes 2 ☐ I
or 28g	Director	10e. Street and Number				Zip Code				10g. Citiz	en of What Co	ountry?
s 23a		113 White St.	12 Was Dagedon Fr	an in II C		21804		-2 (0	4. ٧ ١		.S.	riana Indian
natural, or Items 23s or 28s-1 ehow dical Exeminar must be notified at	by Funerai	11. Marital Status n/a 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, s	pecify Cubar	Specify:	Puerto R	ofy Yes or No- ican, etc.)		4. Race - Ame Black, Whit Specify: B1	te, etc.
4 74	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			Decedent's U (Give kind of life. DO NO1	work done di	uring most	of working	g	16b. Kin	d of Business	/Industry
Hygiene. other than	Con	n/a				n/a					n/	a
alth and Mental Hygis 27 le marked other r traumatic event.	Be	17. Father's Name (First, Middle, Last) Wilford L. Leonard							(First, Middle, Potts	Maiden S	Sumame)	
mark mark	2	19a. Informant's Name/Relationship (7		196	o. Mailing Addre					er, City or	Town, State,	Zip Code)
f Health ar		Taneka D. Potts/mo	ther	1	3 White							, - ,
ent of Heali nt: If Item 2 ry or other		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Specify		cemete	Disposition (fing, crematory of Acres	or other place	·	Da 7/9/2			ation - City or	
Department of P Important: If Ite any injury or of 2059.		21. Signatur Truneral Survice Licen	san		Lewis	and Address N. Wa	s of Facility	Fune:	ral Hor bury, 1	ne		
nysician Medical		Immediate Cause (Final disease or condition										Interval Between Onset and Death
xaminer	ical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Myocardi Due to (or as a composition of the com	consequence	of):							
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			For State Registrar	State	of Maryla	•		of Health and	Mental Hygie	ene 1. No 2005	22110
			Hegistrar Decedent's Name (First, Middle)	a, Last)			, imouto	0, 000	2. Date of Death		3. Time of Death
	Physicia		Shirley	Elaine	Li	ttleton			June 23	Day Year 2005	11:00 M
	/Medic Examin		4a. Facility Name (If not institution			00200011	4b. City, To	wn, or Location of Dea		4c. County of Dear	
	LAGITIT	C.	1008 Riverhous	se Drive			Sali	sburv		Wicomio	ro
	Funeral		5. Social Security Number	6. Sex	7. Age (In)	vrs. last birthday,	If Under 1 Y	ear If Under 24 Hr ays Hours Mii		(ear) 9. Bin	thplace (State or Foreign buntry)
	Director		217-30-8692	1 □ M 2 🔀	69	Yrs.		,	4/12/19:		yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c.	. City, Town or L	ocation				10d. Inside City Limits
	/anyl	5		omico		Salisbu	cv				1 ☐ Yes 2 🔀 No
	the t	rect	10e. Street and Number				10f. Zip Co	ode	100	g. Citizen of What Co	ountry?
	3a or		1008 Riverhous	se Drive			21	804		USA	
	deatl	ner	11. Marital Status		Decedent Ever i	n U.S. 13.	Was Deceden	t of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - Ame Black, Whit	
ထ္ထ	or ite	by Funeral Director	1 Never Married 2 Mar	ried 1 □ Ye	es 2⊠No Give		1 ☐ Yes 2 ☐		,		white
21215-0036	within 72 hours after death with the Maryland ene. then "Latural", or items 23a or 28a-f show then "Redical Examinating the natified at	d b	3 ☑ Widowed 4 □ Divorced	Year	or Dates:	16a Dass	death Havel C	and the state of t	14	Bb. Kind of Business	
쟌	n 72 nat	Completed	(Specify only highe			(Give	edent's Usual C e kind of work o DO NOT use i	tone during most of w	rorking	D. Killa of Business	industry
12	withi ene. then	omb	Elementary/Secondary (0-12)	Colleg	ge (1-4or 5+)	Bookl	keeper			Retail	
	filed I Hygie other	BeC	17. Father's Name (First, Middle,	Last)		'		18. Mother's N	ame (First, Middle, Ma	aiden Sumame)	
اعد	should be and Mental a marked o umatic eve	To B	Herman Edward	Townsen	d				Pauline Ph		
Maryland	2 should and Men ie marke eumatic		19a. Informant's Name/Relations				_		Rural Route Number, (1
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Menth Hygens. If item 27 is marked other then 'natural', or items 23a or 28a-f show if item 27 is marked other then 'natural', or items 23a or 28a-f show or other treumatic event, the Medical Examinating Indianal.		William Hudsor	ı/son							gs,MD 21837
Ore	ges 1 t of H if ite or otl		20a. Method of Disposition 1 ☐ Burial 2X Cremation	3 Removal fr	om State	b. Place of Disp cemetery, cre				oc. Location - City or	
Baltimore,	artment of hortents if its		* 4 □ Donation 5 □ Other (S			Salisbu		atory 6/	24/05	Salisbury,	MD
Bal	De a		α		_ <	F	Tollowa	v Funeral	Home Profe	essional A	ssociation
			23a. Part 1. Enter the disease, o	complications th	nat caused the c	death. Do not en	out Sno	W HILL RO. If dying, such as card	 Salisbur ac or respiratory arres 	ry, MD 218	04 Approximate
	Physician		Immediate Cause (Final	only one cause	on each line.						Onset and Death
	/Medical		disease or condition resulting in death)	a Cue	o to (or as a con	sequence of):	- MC	was, M	etastatic		3 yrs.
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-	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a con	sequence of):					
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687	ficate phys s the	edlc		đ.							
Box (death certificat e attending phy d for use as th	N/M	IF FEMALE: 23b. Was decedent pregnant		, outcome of pre					23d. Date of de	livery
	death e atte d for	Icla	in the past 12 months? 1 ☐ Yes 2 🗖 No	4□P	ive birth 2 1 1 regnant at time		□Ectopic preg □ Other (spec			Month	Day Year
P.0	that the deatl ed by the atte detached for	Physician/M	9 🗆 Unknown		Inknown						
Ś	es be	by	Part II. Other significant conditi	ons contributing	to death but not	t resulting in the	underlying cau	se given in Part I.			o the cause of death? robably 4 □Unknown
ord	w requir been si should I	ted	COPD						- Tes		
Record	e law has b	Completed							24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
		S							1 ☐ Yes 2[XNo 1 ☐ Yes	2 🔀 No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	4.501	2 ☐ ER/Outpatie			eath <i>(Check only one)</i> Home 5 🔀 Residen		- ' '
o		\vdash	1 ☐ Yes 2 No 27. Manner of Death	28a. C	1 ☐ Inpatient Date of Injury Month, Day Yea			Injury at Work?	28d. Describe hov		scriy)
lon	Attending F r death. ector: After by the funer	tlor	1 X Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (/ igation	Month, Day Yea	ar) Injury	м	Work? 1 ☐ Yes 2 ☐ No			
Division		iffica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. F	Place of Injury - a	At home, farm, s	treet, factory, o	office	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
Ö	spitel or ours afte serel Dire	Certification:									
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edical		Examiner: On the					ice, and due to the cat courred at the time, dat		
	To th withir To th comp	Me	29b. Signature and title of certific	er /				icense number		d. Date signed (Mon	
	3) CS	1 10	P			02498	6	6/27/0	3
	P	3	30. Name and address of person	who completed	cause of death	(Item 23a) (Type	Print)	2 /	<i>i</i>		
	0		Robert J.	Keilly N	10 560	Cluer St	re Un 6	101 Salish	bury md.	21801	
	Sta Regist		31. Date filed (Month, Day, Year JUN 2	8 2005	Slave	15	goarle				:

			1 - For State Registrar	State of Ma	aryland /		ent of H		d Mental I		700	 5 23111	
			Hegistrar Decedent's Name (First, Middle,	Last)		Oortme	Date of L	Jean	2. Date of	Reg. No.	y. • • • •	3. Time of Death	-
	Physici		Mary Margaret	Langley					July	. Da	*	ar	ı
	/Medic Examin		4a. Facility Name (If not institution,			4b.	City, Town, or	Location of D			c. County of D		-
			43705 Sterling	Dean Lane			Hollyw	ood			St. M	ary's	
	Funeral		, , , , , , , , , , , , , , , , , , , ,	5. Sex 7. Age	e (In yrs. last bi	Mor	inder 1 Year oths Days	If Under 24 I Hours N	Ain. (Month.	. Dav. Year	9.	Birthplace (State or Foreign Country)	n
	Director		216-48-9999	TUW Zabir	58	Yrs.			Dec.	18, 1	946 W	ashington D.	C.
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Location	1					10d. Inside City Limits	
	Mary -1 sh	to	Maryland St.	Mary's	Ho11	ywood						1 □ Yes 2XXNo	,
	hours after death with the Maryland tural', or Items 23a or 28a-1 show at Examinar must be nulliked at	Director	10e. Street and Number		11011	-	f. Zip Code			10g. C	itizen of What	Country?	
	th wit	aiD	43705 Sterling	Dean Lane			20636			U	.S.A.		
	ems erm	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was E	ecedent of Hi specify Cuba	spanic Origin? n, Mexican, Pi	? (Specify Yes or uerto Rican, etc.	No-		merican Indian, /hite, etc.	
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2	be filed ntal Hygi ed other event, II	ВеС	17. Father's Name (First, Middle, L.	ist)				18. Mother's	Name (First, Mic	dde, Maidei	n Sumame)		
<u>Ja</u>	should be ind Mental s marked o	2	Ralph Cooper					Prici	illa Nic	kerso	n		
Maryland			19a. Informant's Name/Relationshi						r Rural Route Nu			,	
	is 1 and 2 of Health a Item 27 ls other trai		Jack D. Langley	/ Husband					Lane Ho			ryland 20636	
ŏ			20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3			of Disposition ery, cremator,				20c. L	ocation - City	or Town, State	
Baltimore,	it. Pa rtmer rtant njury		' 4 □Donation 5 □Other (Spa 21. Signature of Suneral Service Li		Brins	field			8-2005			Hall, MD	_
Ba	permit. Page Department of Important: If any injury or once.		Edward W. Brinsi		M00052							Home, P.A. d 20650-0279	
	= .		23a. Part1. Enter the disease, or o	omplications that caused	the death. Do						агутан	Approximate	
	Physician	2	shock, or heart failure. List o Immediate Cause (Final	nly one cause on each in	ne.	1 .						Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)		a consequence		CH	NCER	-		-	2 mouths	-
	Examiner				,								
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	of):							
	scute ind transi	Examiner	triat initiated events	с									
90,	cate be executed by sician and the burial-transit	ũ	resulting in death) Last	Due to (or as	a consequence	e of):							
8760,	death certificate be executed e attending physician and id for use as the burial-transit	ledicai		d		·							_
9 x	eath certific attending p I for use as I	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						22d Date of	ata li	
Вох	atten atten	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal deat		oic pregnancy or (specify)				23d. Date of Month	Day Year	
o.	that the de ed by the detached	Physician/M	1 ☐ Yes 2 📉 No 9 ☐ Unknown	9☐ Unknown									
<u>0</u>	res that igned b	by PI	Part II. Dther significant condition	s contributing to death b	ut not resulting	in the underly	ing cause give	en in Part I.	23e. E	oid tobacco	use contribut	e to the cause of death?	
Records,	law requires as been sign 2 should be								_ 1	☐ Yes 2	100 3 E	Probably 4 Unknown	
SC	aw re	Completed								Vas an	24b. Were	autopsy findings available)
H.	: The la cate ha ; page 2	mo								utopsy erformed? es 2 X No	death	to completion of cause of 1? Yes 2 XNo	
Vital	sician: certifica rector, I	Be C	25. Was case referred to medical examiner?					26. Place of	Death (Check or				
of V	Physician: this certific ral director,	7°	1 ☐ Yes 2 X No	Hospital: 1 Inpatie			DOA Othe	4 Nursin	ng Home 5X P	Residence	6 □Other (S	Specify)	
	ding P. h. After I	on:	27. Manner of Death 1 XNatural 5 ☐ Pending		ry y Year) 28b.	Time of Injury	28c. Injury Work		28d. Descri	be how inju	iry occurred		
isio	Attending r death. ector: After by the fune	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ot be Geo Place of Init	unu Athomo f	M		Yes 2□No	29f Logotic	on (Ctonner)	and Alventage	Cont. Co. to Manha	_
Division	i git d	Certification:	4 Homicide determin	28e. Place of Inju- building, etc	c. (Specify)	raim, street, ra	ictory, omice		City or	Town, Stat	e)	Rural Route Number,	
	pita urs eral		29a, Certifier 1 Certifying	Physician: To the best	of my knowledd	ne death occu	rred at the tim	ne date and n	lace and due to	the cause/s	and manner	as stated	_
	To the Hosp within 24 ho To the Func completely f	edicai	(Check only 2 Medical E	xaminer: On the basis of and manner sta	f examination a	nd/or investig	ation, in my op	oinion, death o	occurred at the tir	ne, date an	d place, and	due to the cause(s)	
	To th withir To th comp	Me	29b. Signature and little of certifier				29c. License	number		29d. Da	ate signed (M	onth, Day, Year)	
)			1 tama	4 hom	m	>	D	4172	8	,Tı	uly 6,	2005	
			30. Name and address of person w	ho completed cause of d	leath (Item 23a)) (Type, Print)						=005	
			Patrick Cross,			Notch	Road I	Hollywo	ood, Mar	y1and	20636		_
	Sta Regist		31. Date filed (Month, Day, Year)	1 2005 32. Resistra	ar's Signature	ha	2						
			70L 1		THE PARTY								

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Ramona Brenda Lankford June 24 2005 4:45 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2035 Church Creek Road Cambridge Dorchester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 XF Months Days Yrs. Director 214-42-7607 63 Sept. 10, 1941 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other then "neturel", or Items 23a or 28e-1 ehov other treumatic event, the Madical Examinar must be inclined at 1 ☐ Yes 2 No Director MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2035 Church Creek Road 21613 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore. Marvland 21215-0036 1□ Yes 2 No þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7; th and Mental Hygiene. 7 Ie marked other then "n. Elementary/Secondary (0-12) College (1-4or 5+) cafeteria cook public school 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Parks Abbott Lorraine Robbins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) init. Pages 1 and 2 st partment of Health and ortent: If item 27 le r 2035 Church Creek Road, Cambridge, MD 21613 Gorman Lankford husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Park 6/29/05 Cambridge, MD permit.
Deportre
Importe
any nju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Dur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician myocardial Infarction 30minutes /Medical Due to (or as a consequence of): Examiner Cerchial VADCULAr acci dent Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury use as the burial transit Due to (or as a consequence of): mellitu that initiated events resulting in death) Last the attending physician Box 68760, certificate be Physiclan/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown þ been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes Physicien: 25. Was case referred to medical 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0059973 non 6-24-05 ddress of person who completed cause of death (Item 23a) (Type, Print) lohnson Cambiage, mo errycia. 100 Bramble St 2005 Register's Signature 31. Date filed (Month, Day, Registrar

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			1 _ State	State of Maryta	•	ent of Health and cate of Death	, ,		00:10
			Registrar 1. Decedent's Name (First, Middle, Last	st)	Ochine	ale of Death	2. Date of Death	2005	3 Time of Death
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	/Medio Examir		4a. Facility Name (If not institution, give			City, Town, or Location of Deal	h 06 -	24-05 4c. County of Death	10010
	Exami	ei		General F	to Spital	Cambridge		Dorch	1
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yr	rs. last birthday) If U	nder 1 Year If Under 24 Hrs	8. Date of Birth		nplace (State or Foreign
	Director		220-01-7858 1	1 □ M 2 X F	7 Yrs. Mon	ths Days Hours Min.		918 Ma	Ryland
	p ,		Usual Residence of Decedent	100	City, Town or Location				
	Maryland -f show lied st	_	10a. State 10b. County	<u> </u>	0 .	. 1			10d. Inside City Limits
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\mathcal{I}	with the a or 28a be roti	급	11 - 1 - 1	. Charl	_	7 1/13	109	J. Citizen of What Cou	intry?
Q	death	Funeral Director	426 Oakley	12. Was Decedent Ever in	U.S. 13 Was D	2/6/3	Specify Yes or No-	14. Race - Amer	ican Indian
E	r iten	ᇤ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	1	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	
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5-003	72 ho natur ilical	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Decedent's	Usual Occupation	ding 16	b. Kind of Business/li	ndustry
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Maryland	iges 1 and 2 should be filed within 72 hours atler death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other then 'naturel', or items 23a or 28a-f show or other treumatic event. It a Madical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	1771 1991 19	Iress (Street and Number or R			
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Ħ	permit. Page Department o Important: If any injury or once.		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licer	nsee .	ordtown (e And Address of Facility	0/05	ambridg	e mary land
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			23a. Part1/Enter the disease, or com shock or heart failure. List only	aplications that caused the de	ath. Do not enter the	mode of dying, such as cardia	or respiratory arrest	ipri age	Approximate
	Dhysisian		Immediate Cause (Final	(1)					Interval Between Onset and Death
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x 68	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of preg					
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<u>></u>	Physicien: this certific al director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐	Othor		ce 6 Other (Speci	(fv)
lof			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		,,
ioi	Attending r death. ector: After y the fune	atlc	2 Accident investigation	n	M	1 Yes 2 No			
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	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	Check only 2 Medical Exar	miner: On the basis of exami	nowledge, death occur ination and/or investiga	rred at the time, date and place ation, in my opinion, death occu	, and due to the caus	se(s) and manner as and place, and due	stated. to the cause(s)
	the the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License number		. Date signed (Month,	
	To Toon		233. Signature and the or certifier		110	10 c 7 1 14	290.	(1) 7	105
			20 No. 20	completed assume of death (to	/V()	U) 1290		01~11	21613
			30. Name and address of person who	- () TIMIA TA	(Type, Print)	503 A	Mur Si	F. Canl	on by MAD
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	2 4	100		7
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dav Year Allen Lytte July 1552 James 03 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bathmore University Center-SICU Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 10 M 2□F Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 231-40-3775 Yrs Director 80 24 36 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or Items 23e or 28e-f show eny injury or other treumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 € No Director Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23734 Kingston Creek Road 20619 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 1958-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 1978 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Senior Financial Analyst</u> Government Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James B. Lytle 2 Ovelia Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23734 Kingston Creek Road, California, MD 20619 Glenda R. Lytle / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) 9-19-2005 Arlington, Virginia Arlington National 21. Signatu 22. Name and Address of FacilityBrinsfield Funeral Home, P.A. Edward N. Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** tailure respiratory disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 5yrs Csophageal
Due to (or as a consequence of): cancer Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine ig physicien and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day Month 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. 4 Nnknown 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2/4 No certificate 1 Yes 2 No 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death Check onl one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 15962 03 05 30. Name and added of person who completed cause of death (Item 23a) (Type, Print) Amy Marks 22 S. Greene St. Baltimore, MD 21201 31. Date filed (Month, Day Year) 32. Regis ar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Margaret J. Lynch 6:10 9,2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Lions Manor Nursing Home Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 7, 1940 e (State or Foreign **Funeral** Months Days Min 1 ☐ M 2 ☑ F Maryland 65 Yrs. 218-38-0295 Director Usuel Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Allegany Mt. Savage Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 12806 New Row RD., NW 21545 238 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other traumatic avant, the Medical Examiner of 1 Never Married 2 Married ynch, Margare ŏ Baltimore, Maryland 21275-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Uniform Rental Co. Salesperson 12 2 should be filed w and Mental Hygier is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence R. Howard Doris M. (Stone) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: if item 27 is a any injury or other traun Ronnie C. Lynch/husband 12806 New Row RD., NW, Mt. Savage, MD 21545 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens 7/2/05 LaVale, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mmediate Cause (Final Physician disease or condition resulting in death) Sonic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I ed by the a detached f signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes ate has been si page 2 should Be Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Hospital or Attanding Physician: filled in by tha

within 24 hours after death To the Funeral Director:

State Registrar

Medical

29a. Certifier

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date liled (Month, Day, Year) JUL 0 1 2005

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State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Elizabeth Lord 23, 2005 June 11:22P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince Georges 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2XF 045-22-3973 Yrs. 86 Director Washington, DC Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 27 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at MD Director Prince Georges 1X Yes 2 □ No Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10212 Prince Road #105 20744 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education ify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h . Pages 1 and 2 should by iment of Health and Menta tent: If item 27 is marked George N. Prokos Florence B. Kimmel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Pruitt - Daughter 12806 Poplar Street, Silver Spring, Maryland 20904 y or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 07/01/2005 Brentwood, Maryland 21. Signature of Funeral Service Litensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 Part 1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Hemorrhagic Stroke /Medical Due to (or as a consequence of): Examiner Lunp Cancer Sequentially list conditions, it any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of), the death certificate be executed Breast Cancer and burial-tran resulting in death) Last Due to (or as a consequence of) attending physicien Brain Edema Completed by Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) the t 9 Unknown 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 □Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Certification: To this the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Atter! Attending 1 🛚 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No s etter death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 5 To the Hospital - within 24 hours e: To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical SHANZIL, UD 29c. License num D0059228 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) June 27, 2005 0 30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print) Elvira Pasmanik, MD, 14201 Laurel Park Drive, #226, Laurel, Maryland 20707 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 29 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

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Division of Vital Records,

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F			ene 2005	23117
П	Physic	ian	Decedent's Name (First, Middle, Last)			· · · · · · · · · · · · · · · · · · ·	June 25,	Day Year 2005	3. Time of Death
	/Medi Exami		Mary Elizabeth 4a. Facility Name (If not institution, give	Little street and number)		4b. City. Town, o	r Location of Death	1	4c. County of Deat	1:45 PM M
4:	Lxaiiii	1CI	Heart Heritage Es	tate			eet		Harford	
h	Funeral		5. Social Security Number 6. Se 170–20–2689	x 7. Age	e (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Birtl	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent		91 Yrs.			Oct. 27,	1913 Pen	nsylvania
	aryland show	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	he Ma 188-19	Director	Maryland Harford		Str					1 X Yes 2 No
	with t	Dir	10e. Street and Number 3708 Grier Nurser	v Pood		10f. Zip Code	: <i>I</i> .	100	J. Citizen of What Co	untry?
	death ms 23	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		Decify Yes or No-	USA 14. Race - Amer	ican Indian.
98	or ita		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X N If Yes, Give	lo	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Rican, etc.)	Black, White	hite
9	72 hours after death with the Maryland "natural", or Itams 23s or 28a-f show sdisal Examinar must be notified at	ed by	3 XWidowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	100 Door	dent's Usual Occup				
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21	be filed within 72 hc ital Hygiene. id othar than "natur avant, the Medical	Completed		4	T)	Home Mak	er		Own Home	2
Maryland 21215-0036	ould be filed Mental Hygis arkad othar atic avant, It	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma	niden Sumame)	
ıry	ages 1 and 2 should b ant of Health and Ments t; If itam 27 is markad y or other traumatic a	P	Willard J. Lynch 19a. Informant's Name/Relationship (T)	roe. Print)	19b. Maili	ng Address (Street		letzell	City or Town, State, Z	in Code)
	and 2 sealth ar		Margaret Herman/Da					ington, M		,
Baltimore,	of Height		20a. Method of Disposition 1 🗆 Burial 2 🖾 Cremation 3 🗆 F		20b. Place of Disponentery, cre	osition (Name of matory or other place	:e)		c. Location - City or 1	own, State
ri m	d a ma		*4 ☐ Donation 5 ☐ Other (Specify)		Metropoli	tan Crema	tory 6-28	8-05 <i>E</i>	Alex., Vir	ginia
Bai	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licens	9001	2	2. Name and Addres	ss of Facility DeV 2222 Wis Washingt	ol Funera consin Av	1 Home 7e N.W. 20007	
	rnysician /Medical Examiner	ner	it any, leading to immediate	Due to (or as a	the death. Do not ene. O IS 10 VIV a consequence of):				t,	Approximate Interval Between Onset and Death 4 LARS
68760,	death certificate be executed e attending physician and id for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):					
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rds, P.	iw requires that the s been signed by th should be detache	by	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.		cco use contribute to	
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Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Othor		h (Check only one)		ASSISTED
of	ding Phys h. After this funeral dii	atlon: To	1 Yes 2 No 27. Manner of leath 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injun (Month, Day	y 28b. Time o	f 28c. Injury Work	at 'es 2 □ No	me 5 Residence 28d. Describe how	ther (Speci injury occurred	by CARE
Division	2 5 5 6	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, farm, sti . (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	Hos 24 h Fun stely	edical	one)	ician: To the best of ner: On the basis of and manner stat	f my knowledge, deat examination and/or in ed.	vestigation, in my op	pinion, death occur	and due to the caus red at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
)	To that within To the comple	W	29b. Signature and title of certifier	Syl 1	WV.		3988	j j	Date signed (Month,	2005
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	Sta Registr		JUN 2 9 200	5 September 1	r's Signature	well				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) JUNE 27, 2005 **Physician** 2:40 P LEVY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL 377 WASHINGTON AVENUE GLEN BURNIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Hours Min Months Days 1 M 2 F Yrs. DEC 17, Director 42 1962 MARYLAND 217-48**-**71**9**3 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County iral, or items 23e or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo MARYLAND ANNE ARUNDEL GLEN BURNIE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 21060 377 WASHINGTON AVENIE UNITED STATES Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 MENTALLY DISABLED NONE O other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PAIII. N. LEVY GALE RICHTER ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 SHORT STREET, GAITHERSBURG, MD SUSAN L. BENOVITZ, SISTER injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Importent: If any injury o once. ^ 4 □ Donation 5 □ Other (Specify) MT. LEBANON CEMETERY 6/30/2005 ADELPHI, MARYLAND 21. Signature of Funeral Service 222 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. onald. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the darth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC BLADDER CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a sonsequence or): Examine nding physician and use as the burial-transit The law requires that the death certificate ba executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for L in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I the signed by detache 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown MENTAL RETARDATION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmad? 2**X** No 1 ☐ Yes Division of Vital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Yes 2 ER/Outpatient <u>L</u> 3□ DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1X Natural 5 Pending 1 Tes 2 No investigation death. 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide hours after within 24 hours a To the Funerel 6 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number nnun D23867 JUNE 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 29

Box 68760.

Records.

21012

ARNOLD, MARYLAND

THOMAS WALSH, M.D., 477 PENINSULA FARM ROAD,

2005

🔐. Registrar's Signature

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			Decedent's Name (First, Middle, Last)			inouto or i	Douth		2. Date of De) UU	3.) infig of	Death A
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	/Medio Examir		4a. Facility Name (If not institution, give str			4b. City, Town, or	r Location of		30-1	-	ounty of Dea		
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J.	ges 1 and 2 it of Health if item 27 I or other tre		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	ee)	Da	- 4			Town, State	
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Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee			2. Name and Addres						Marylai	
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			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	tions that cauted the cause on each line.	death. Do not ent	er the mode of dyin	g, such as	cardiac or	respiratory a	ırrest,		Approximate Interval Betv Onset and D	veen
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):								
1	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events										
0,			resulting in death) Last	Due to (or as a co	ensequence of):								
9289	cate b	dica	d.										
9 ×	ding p	/Me	IF FEMALE:	. If ves, outcome of p	regnancy								
Вох	atten for u	Physician/Medical	in the past 12 months?	1 Live birth 2 ☐	Fetal death 3	Ectopic pregnancy Other (specify)				230	d. Date of de Month		'ear
0	that the dead by the detached	Jysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	0					_			
۵,	signed b		Part II. Other significent conditions contr	buting to death but no	ot resulting in the u	nderlying cause give	en in Part I.		23e. Did 1	tobacco use	contribute t	o the cause of de	eath?
rds	w require been sig should b	edt	Jepsis.						1 🗆	Yes 2□h	No 3□P	robably 4 🗗	nknown
Records,	2 5	Completed by				<u></u>			24a. Was	an 2	24b. Were a	utopsy findings a completion of ca	available
E.	The I	Con							perfo	ormed?	death? 1 ☐ Yes		
Vital	ysiclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	spital:		0.1			Check only				
of	99 (0 =	-T	1 Yes 2 No	1 Mnpatient	2 ER/Outpatien		4 🗆 1401		e 5 Resi			ecity)	
on	ding Phy h. After this funeral o	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	ar) Injury	Worl	γαι ∢? Yes 2 □ ħ		3d. Describe	now injury o	ccurred		
Division	Atten r deal sctor: by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, farm, str						lumber or R	ural Route Numb	per,
Ö	al or safter	Certification:	4 Homicide determined	building, etc. (S	ipecify)				City or To	wn, State)			
	l hour uners		29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine	ian: To the best of m	y knowledge, death	n occurred at the tim	ne, date and	d place, an	d due to the	cause(s) an	d manner a	s stated.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medicai	one	and manner stated.									
1	To To		29b. Signature and title of certifier	0.20		29c. License						th. Day, Year)	
,			30. Name and address of person who com	plated source of doors	/Item 02a) /T	Drint\	$-\infty$			July	8,200	75	
	10		STANROL FILL A) Sir	i thosoim	1 of 200	Otimo	re					
Г	Sta		31. Date filed (Month, Day, Year)	2. Registrar's	Signature	1 of Ba							

			1 - For State Registrar	State of Maryla	-	artment of F			ene 200	5 23120
			Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
	Physici		Gabriella N	Marie Eile	ne Ma	ynard		June 26	, 2005 Y	8:15 A ^M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			r Location of Death		4c. County of	
	Exami		9750 Martha's La	nding Drive		Ocean C	itv		Worces	ster
	Funeral		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday)	If Under 1 Year		8. Date of Birth		Birthplace (State or Foreign Country)
	Director		217–63–3405	⊐м 2 ^{КБ} F 3	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 4/1/200	2	Maryland
	Di Name		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	postion				10d Jacida Oita Livia
	shov	'n	Maryland Wicomic		alisbur					10d. Inside City Limits 1 X Yes 2 No
	Ne M	Director		0 0	allsbut	-				
	a or		10e. Street and Number 1008 Adams AVe.,	Apt 2D		10f. Zip Code 2180	14	10	g. Citizen of Wh USA	at Country?
	72 hours after death with the Maryland natural, or ttems 23a or 28e-1 show idical Examiner must be rivillised at	Funeral	11. Marital Status	12. Was Decedent Ever in	118 13		lispanic Origin? (Spe	acity Vac or No.		American Indian,
	ter d	Ľ.	17. Marital Status 17. Never Married 2 ☐ Married	Armed Forces?	10.3.	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		White, etc.
38	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1☐ Yes 2XNo	Specify:		Specify:	White
ğ	72 hou		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	. 1	6b. Kind of Busin	ness/Industry
215	C _ 36	ple	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done on DO NOT use retired	during most of work d)	ing		
21	The car	Completed	0	0	n/a				n/a	
Maryland 21215-0036	0 = >	Be (17. Father's Name (First, Middle, Last)	_			18. Mother's Name			
/la	as 1 and 2 should be of Health and Mental litem 27 is marked or other traumetic ever	10	Joshua Garland Ma	ynard			Amanda	Lynn Ha	ley	
lan)	2 sho and I is me		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	ng Address (Street	and Number or Rura	al Route Number,	City or Town, St	ate, Zip Code)
	and ealth m 27		Joshua G. Maynard	· · · · · · · · · · · · · · · · · · ·			e., Apt.		bury, M	21804
ore	ages 1 ar at of Hea if item or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		 Place of Dispo cemetery, crei 	natory or other place	ce)			ty or Town, State
<u>Ĕ</u>	Pages nent of ant: if it ury or o		`4 □Donation 5 □ Other (Specify		eadowrid Park	dge Memor	ial 7/6/	05 E	lk Ridge	e, MD
Baltimore,	permit. Page Department of Important: If any injury or		Signature of Fulleral Service Licen	see :	22	Name and Addre	ss of Facility Funeral H	ome Prof	essiona'	L Association
<u> </u>	90 E 2 3		Marie St.	homos	CESP	501 Snow	Hill Rd.	Salisbu	ry, MD	21804
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that daused the de one cause on each line.	eath. Do not ent	er the mode of dyin	ng, such as cardiac o	or respiratory arres	it,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Drown	vin 9					Onset and Death
	/Medical		resulting in death)	Due to (or as a cons						
п	Examiner		Sequentially list conditions,	b						
	ס א	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
	The law requires that the death certificate be executed the saben signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	oe ex		resulting in deathly cast	Due to (or as a cons	equence of):					
876	physic the b	dicai	•	d						
9	eath certific attending p	Me	IF FEMALE:	00-14						
Вох	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1☐Live birth 2☐F	etal death 3	Ectopic pregnancy	,		23d. Date of Month	
<u>o</u> .	the de py the a tached f	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	f death 5	Other (specify)				22/
<u>a</u> .	that the ed by detac		Part II. Other significant conditions of	ontributing to death but not	esulting in the u	ndarhina causa an	on in Part I	23e Did toba	cco use contabi	ite to the cause of death?
ds,	signe signe	1 by	Tarris outside of the contraction of	and the second section of the section of t	oodiiing iir tile d	ndonying oddao gw	on my art.	1 Yes	M	□ Probably 4 □Unknown
0	w requir been si should	Completed								
}ec	has be as be as be as be as be as s	ldu						24a. Was an autopsy	prio	re autopsy findings available r to completion of cause of
al F		Co						10 Yes 2	No 15	th? Yes 2□ No
Vital Records,	Physician: T r this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death			
of	hys this	은	1X Yes 2 No 27. Manner of Death	1 Inpatient 2	ER/Outpatier		4 Nursing Ho			(Specify) at scene
L C	ling After funer	lo	1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wor	yat k? Yes 2∭ No	28d. Describe how Sub, ect		d
Division	or Attending Patter death. Director: After to in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be	6-26-05 28e. Place of Injury - A						or Rural Route Number,
.≥	or A after Direction by	ertit	4 Homicide determined	building, etc. (Spe	icify)	ming 120		City or Town,	State) 475	o martha's
_	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	a Ce	29a. Certifier 1 ☐ Certifying Ph	sician: To the best of my k		0	· · ·	anding Tr		m Dr. in D
	24 hi Fun stely	edica		iner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my o	pinion, death occurr	ed at the time, dat	e and place, and	I due to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. License	e number	290	f. Date signed (/	Month, Day, Year)
	F 3 F 0		ing his,	mis		OCM	Œ		June 27	
	02		,		tom 23a\ /Tun-	Print				-
	7		30. Name and address of person who	impleted cause or death (I	23a) (1ype,	''''111 Pen	n Street	Baltimo	re, Mar	yland 21201
	Sta	té								
	Regist		31. Date filed (Month, Jay, Year) 0	2005 32. Rightstrar's Sig	H. 1	books				

			epartment of Health and I Certificate of Death		ene	23121
Physi /Med		1. Decedent's Name (First, Middle, Last) Joan T. Mahalik		2. Date of Death Month June	22, 2005	3. Time of Death 2:30 a M
Exam	iner	4a. Facility Name (If not institution, give street and number) 717 Mashie Court	4b. City, Town, or Location of Death Arnold	1	4c. County of Death Anne	Arundel
Funera Directo		5. Social Security Number 578-50-7239 Usual Residence of Decedent 6. Sex 1 M 2 Ref 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)		place (State or Foreign intry)
Maryland f show	tor	10a. State 10b. County 10c. City, Town MD Anne Arundel	or Location Arnold			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
with the a or 28a.	Director	10e. Street and Number 717 Mashie Court	10f. Zip Code 21012	109	g. Citizen of What Cou	ntry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Importent: If Item 27 is marked other then "natural", or Itams 23a or 28a-f show any injury or other treumatic event, the Medical Exercites must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 【XNo Specify:	pecify Yes or No- o Rican, etc.)	USA 14. Race - Ameri Black, White, Specify: W	
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental hygiene. It is marked other then "natural", or treumatic event, the Medical Exstantransumatic event, the Medical Exstantransumatic event, the Medical Exstantransumatic event.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired) Homemaker	king 16	Sb. Kind of Business/In	
rland indicated indicated indicated indicated indicated indicated in the incomment in the indicated in indica	To Be C	17. Father's Name (First, Middle, Last) Paul Torregrossa		ne (First, Middle, Ma Trippie	niden Sumame)	
Maryla and 2 should alth and Men 127 is marke			Mailing Address (Street and Number or Ru 17 Mashie Court, Ar		City or Town, State, Zip 21012	o Code)
altimore, mit. Pages 1 ar partment of Hea portent: If Item y injury or other		1 Burial 2 Cremation 3 Removal from State	Disposition (Name of y, crematory or other place) Crematory June	e 23,	oc. Location - City or To Baltimore,	
Balti permit. Departin Importe any inju	ouce.	21. Signature of Fineral Service Licensee	22. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie	P.A. Seve:	rna Park F rna Park.	uneral Home
Pnysicia /Medica	_	resulting in death)	ot enter the mode of dying, such as cardiac c Heart Disease			Approximate Interval Between Onset and Death 5+ years
Examine	r	Sequentially list conditions. Tarry, leading to minimodule cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of Hypercholester Cue to (or as a consequence of Cardiomyopathy) Cardiomyopathy	olemia			5+ years
68760, ficate be executed physician and is the burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last Cardiomyopathy Due to (or as a consequence of the con				5+ years
O. Box in death certified attending the attending the death use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ⊟Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv	rery Day Year
rds, P. (quires that the n signed by ald be detact	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to t	
	Completed			24a. Was an autopsy performe	prior to co death?	opsy findings available ompletion of cause of
f Vital Reysicien: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?	Othor	ith (Check only one)		
on of ding Ph h. After th funeral	atlon; To	27. Manner of Death 28a. Date of Injury 28b. Ti	patient 3 DOA 4 Nursing H	ome 5 Residen 28d. Describe how	ce 6 Other (Special injury occurred	<i>\$</i>)
Divisic all or Attences after death	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
Divi To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Chack only one) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and manner stated.	, death occurred at the time, date and place Vor investigation, in my opinion, death occu	, and due to the cau rred at the time, dat	se(s) and manner as s and place, and due t	itated. o the cause(s)
To the within 2. To the complet	Me	29b. Signature and title of certifier A A A	29c. License number D0036242	290	June 23, 2	
		30. Name and a ld ss of person who completed cause of death (Item 23a) (Eugene Thomas Manion, M.D., 900 Be		303. Annar	xolis. MD	21401
Regi	State strar	31. Date filed (Month, Day, Year) 2.7 2905 32. Redistrar's Signature				

Examiner 4. Facility Name (if not institution, give street and number) 4. Facility Name (if not institution, give street and number) 4. Facility Name (if not institution, give street and number) 4. Facility Name (if not institution, give street and number) 4. Facility Name (if not institution, give street and number) 4. Social Security Number 5. Social Security Number 6. Sex 7. Age (in yrs. last binday) 10 Linker 1 Vest 93 Yes. 10 Linker 1 Vest 11 Linker 1 Vest 12 Linker 1 Vest 13 Linker 1 Vest 14 Linker 1 Vest 15 Linker 1 Vest 15 Linker 1 Vest 16 Linker 1 Vest 17 Linker 1 Vest 18 Linker 1 Vest 19 Linker 1 Vest 19 Linker 1 Vest 19 Linker 1 Vest 10 Linker			1 - For Stete Registrer	State of Marylan		artment of F <i>rtificate of I</i>		ind Mental H	ygier Reg. N	e BAAA	00100
Figure 2 Elizabeth Mauney-Hawkins Successful Supplied (Procedure) Supplied (Procedure	Dhusia		1. Decedent's Name (First, Middle, Last	")						2005	3. Wime of Death
49.93 Alarwich May South School Starty Number S. Size S. Date				vkins						12:20 P	
Special Security Number C. Set Special Securi	Examir	ner		street and number)		4b. City, Town, or	Location of	f Death	4	c. County of Dea	th
The control of the				7 Age /In ure	last hirthday		If Under 2	A Hrs. 9 Date of t			
100. State 100. County 1			578-12-2840	TM office				Min. (Month,	Day, Yea	12 Nort	ountry)
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Thysicin in Medical Cardina Section (Proc. Print) 198	od wit gjene er the	Com	11	Conogo (1 40/ 5/)	Assis	tant Chie	f Ope	rator	C	& P Tele	phone Co.
Thysicin in Medical Cardina Section (Proc. Print) 198	be filk tal Hy d oth event	Be					18. Mother	's Name (First, Midd			
Jane Klotz- Daughter 200. Nethod of Disposition 200. Place of Disposition (State) 200. Date of Dispositio	ould Men Parke Patic	ို									<u></u>
Comment Comm	12 sh h and 7 is m treum										
Comment Comm	1 and Healt em 2				9801	Tribonian sition (Name of	Dr.	Ft. Washi			
23. Signature of gunnal Sarvice (coppee) Work of the first the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest. Physician (Modical Examiner) Physician (Modical Examiner) Physician (Modical Examiner) Examiner Physician (Modical Examiner) Physician (Modical Ex	0 0		1 ☐ Burial 2 🛣 Cremation 3 🗇 F	Tellioval front State							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Inserting in death)	artme orten injury	1		111011					Wa.	ldorf, Ma	aryland
Direction of Course (Final Interval South of Leading of Course (Final Interval South) Direction of Course (Final Interval Int	Dep Imp		Nack A. Wil	1101240	H	untt Fung	ral H	ome			
Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition) Immediate Ca			23a. Part1. Enter the disease, or complete the complete t	lications that caused the death	n. Do not ent	 U BOX I er the mode of dyin 	50, W g, such as c	aldort, Mi ardiac or respiratory	J_ZU(arrest,	004	Approximate
Due to (or as a consequence of): Sequentially list conditions, 2 any, legaring to constrained and proposed agreement of the cause of the conditions, 2 any, legaring to constrained and proposed agreement of the conditions, 2 any, legaring to constrained and proposed agreement of the conditions and the conditions are consequence of):	Physician I		Immediate Cause (Final	Fall	100 1	The Their	P				Onset and Death
Sequentially list conditions:	/Medical			Due to (or as a consequ	uence of):	UTTOTO					
The past 12 profiles of the pa	Examiner		Sequentially list conditions) EM	161/10	Â					
Due to (or as a consequence of): Due to (or as a consequence of):	sit sit	ine	if any, leading to immediate cause. Enter Underlying	Dus to (or as a sonsequ	uarida of):						
Second of Seco	and I-tran	хаш	that initiated events	C. Due to (or as a consequ	ience of):						
Section of the control of the cont	be es				301100 017.						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 Mo 3 Probably 4 Unknown	phy:			d							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 Mo 3 Probably 4 Unknown	nding use a	N/M								23d. Date of deli	verv
The part of the symmetry of the part of th	death e atte	icia	in the past 12 months?	4☐Pregnant at time of de							•
The part of the pa	at the by th tache	hys		9L Unknown							
24a. Was an autopsy performed to completion of cause death? 25. Was case referred to medical examiner? 1	gned be de		Part II. Other significant conditions con	ntributing to death but not resu	ulting in the ui	nderlying cause give	n in Part I.	23e. Dio	tobacco	use contribute to	the cause of death?
24a. Was an autopsy performed to completion of cause death? 25. Was case referred to medical examiner? 1	equir sen si ould							1	Yes 2	2 (1) Mo 3 □ Pro	obably 4 Unkno
25. Was case referred to medical examiner? 1	law asb 2 sl	nple						aut	opsy	24b. Were au	topsy findings availal completion of cause of
27. Manner of Death 1 Pes 2 PNo 28a. Date of Injury 28b. Time of Injury at Work? 2 Accident 3 DOA 28c. Injury at Work? 1 Pes 2 No 28c. Injury at Work? 1 Pes 2 No 28c. Injury at Work? 28c. Injury at	Th ate pag	Cou								death?	
28a. Date of Injury - At home, farm, street, factory, office 28b. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) Michael A Leatherwood MD 12070 01d Line Ctree #202 No 120 No 12	crem Sertific Sector	a	examiner?	Janital.		1011		of Death (Check only	one)		
1 @Natural 2 Accident 3 Suicide 4 Homicide 2 Be. Place of Injury - At home, farm, street, factory, office 2 Be. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier and manner stated. 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) Michael A Leatherwood MD 12070 01d Line Ctr. #202 Walldows MD 20602	this a	H .	1 195 2 19 190	1 □ Inpatient 2 □ I		I 3 L DOM	4 Nurs				rify)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A Leatherwood MD 12070 01d Line Ctra #202 Waldows MD 20602	After fune	lon	1 Natural 5 Pending	(Month, Day Year)		Work	.?		how inju	iry occurred	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A Leatherwood MD 12070 01d Line Ctra #202 Waldows MD 20602	leat for: the	fical	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm str		65 Z [] N		(Street a	nd Number or Ru	ra i Boute Number
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A Leatherwood MD 12070 01d Line Ctra #202 Waldows MD 20602	after Dire	erti	4 Homicide determined	building, etc. (Specify)	ot, lactory, cirioc					al riould rulliber,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A Leatherwood MD 12070 Old Line Ctn #202 Waldons MD 20602	e Hospite 24 hours e Funerel etely filled		(Uneck only 2 Medical Exam)	ner: On the basis of examinat	wledge, death ion and/or inv	occurred at the tim restigation, in my op	e, date and inion, death	place, and due to the cocurred at the time	e cause(s	s) and manner as id place, and due	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A Leatherwood MD 12070 Old Line Ctn #202 Waldons MD 20603	Nithin Fo the		29b. Signature and title of certain			29c. License	number		29d. Da	ate signed (Month	, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A Leatherwood MD 12070 Old Line Ctv #202 Waldows MD 20602	> - 0		> moral	with		1)00	7.103	31	60	2461	
Michael A leatherwood MD 12070 Old Line Ctn #202 Waldows MD 20602		1			23a) (Tvpe.		010.		10		
, a series of a solution of the first of the									_	_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Josephine Ngosa Mukuka June 22,2005 9:30 a~ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Montgomery 9. Birthplace (State or Foreign Country) Park 8. Date of Birth (Month, Day, Year) 9. Birthplace (Country) July 19,1961 Zambia, Africa 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕇 F Days 43 Director <u>941-76-5648</u> Usual Residence of Decedent the Maryland Show 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Medical Executive Fransi Le notified at 1 XYes 2 No Director Prince George Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5902 Knollbrooks Dr. #200 Funerai 20783 Zambia 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Yes 27 If Yes, Give Year or Dates: 1 Never Married 2 Married A∏ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Nursing Aid Health event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be other traumatic Regina Mukuka Steven Mukuka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 19a. Informant's Name/Relationship (Type, Print) If item 27 I Margaret Ricks -sister 5902 Knollbrook Dr. #202 Hyattsville, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State injury or Department Important: If Riverdale Crematory 6-30-05 Riverdale, Md. `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snead Funeral Home&Cremation any 5732 Georgia Ave., N.W. Wash. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sseminated ucobacterium **Physician** luberculosis mon /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been significant categories. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 Yes 2 No 1 Yes Be director 25. Was case referred to medical 26. Place of Death (Check only one examiner? 1 Yes 2 Other ٩ 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification:

Box 68760, 0 ۵. of Vital Records, Physician: this funeral Division or Attending After death. the 24 hours after death filled in by Hospital within 2. the

27. Manner of Dy th Ate V Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only one)

and address

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatur itte of cert own

person who completed cause

29c. License number

29d. Date signed (Month, Dav. Year)

State Registrar

Medical

31. Date filed (Month, Day, Year)
JUN 2 9 2005

of death (Item 23a) (Type, Print) 2. Registrar's Signature

			4 For	State of Ma		nd / Depa	artment of H	Health and	d Mental Hy	/aien	e	. 20101
			1 - State Registrar			Cei	rtificate of	Death	la suluta		2005	
	Physici	an	1. Decedent's Name (First, Middle, L Carol Ann	Mulliki.	n				June 2		MOD Year	3. Time of Death 4:55 p M
	/Medic		4a. Facility Name (If not institution, g				4b. City, Town, o	or Location of D			c. County of Dea	
	Examin	er	Anne Arundel Med		_		Annar		oau		Anne Ari	
	Funeral	1		Sex 7. Age		last birthday)	If Under 1 Year	If Under 24 I		rth		thplace (State or Foreign
or Mr.	Director		213-42-6626 Usual Residence of Decedent	1□M 2∏F	61	Yrs.	Months Days	Hours N	fin. (Month, D Oct. 1	9, 1	943 Was	hington, DC
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Ma-f	ctor	Maryland Anne Ar	rundel	Anı	napolis	5					1 Yes 2 □ No
	or 28	Directo	10e. Street and Number			_	10f. Zip Code			10g. C	itizen of What Co	
	ath w		1974 Scotts Cro					21401			U.S.A.	
	itam itam	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 Yes 2 N		.S. 13. \	Was Decedent of F f Yes, specify Cub	dispanic Origin? an, Mexican, Pi	(Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Ame Black, Whi	
38	irs af	by F	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:			1□Yes 2√2No	Specify:			Specify: wh	nite
21215-0036	2 hor	ted	15. Decedent's	Education		16a. Deced	lent's Usual Occup	pation		16b. l	Kind of Business	
215	thin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	kind of work done DO NOT use retire	d) most or	working			
2	be filed within 72 hours after death with the Maryland Hygiane. I shall be a specified to the then "natural", or itams 23a or 28a-f ehow of other then "natural", or itams 23a or 28a-f ehow avent, the Medical Examination and the notified at	Co	11			admini	istrative	T			ancial o	office
and	od la d	Be	17. Father's Name (First, Middle, Las	_					Name (First, Middle		,	
Maryland	d 2 should be th and Menta 7 is markad traumatic ev	^C	Walter Russel 19a. Informant's Name/Relationship			10h Mailio	a Address /Street	Patri	Rural Route Numb	Benn		Zio Codol
Z	12 h a 7 is rrau		Michael F. Santa	-			Box 907,			208		zip code)
ē,	He He		20a. Method of Disposition	ingero, bon	20b. F	Place of Dispo	sition (Name of natory or other pla		Date		ocation - City or	Town, State
Ë	00		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		1	•			6/29/05	Hur	ntingtow	m. MD
Baltimore,	permit. Page Department Important: If any Injury o		21. Signature of Funeral Service Lic	ense			. Name and Addre					
m —	99 = 8		Buya	1 Mellico	ul	Ra	ausch Fur	meral Ho	me, P.A.	, Ow	ings, M	20736
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that caused y one cause on each lin a. Due to (or as a	2 P	LIZ	er the mode of dyir	ng, such as care	diac or respiratory a	irrest,		Approximate Interval Between Onset and Death
₩ • i	Examiner	<u></u>	Sequentially list conditions, if any leading to intradicts cause. Enter Underlying	b. Due to for as a	1 6	um ov	119					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
Ö,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	conseq	uence of):						
8760	y S	licai		d								
0x 68	entific ding p	/Mec	IF FEMALE:	23c. If yes, outcome of	of progn						110 10 10 10 10 10 10 10 10 10 10 10 10	
m ·	death certifica e attending ph ed for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No	1□Live birth 4□Pregnant at t	2 Feta	I death 3	Ectopic pregnancy Other (specify)	<i>y</i>			23d. Date of del Month	Day Year
o.	at the de by the stached	hys	9 Unknown	9□ Unknown								
Records,	The law requires that the te has been signed by th page 2 should be detache	by	Part II. Other significant conditions	contributing to death bu	t not res	_	nderlying cause giv	ren in Part I.			_	the cause of death?
ဝွ	sw require s been si	ojete	,	. ,					24a. Was		24b. Were au	itopsy findings available
	(0	Completed							- auto perfo 1 ☐ Yes	psy ormed?	death?	completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hamitali C			100		Death (Check only	one)		
0	hys this al di	. To	1 Yes 2 No 27. Manner of Death	Hospital: Anpatier		ER/Outpatient		4 LI NUISIN	g Home 5 Resi	·		cify)
		tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	28c. Injur Wor	yai k? Yes 2 □ No	28d. Describe	now inju	ry occurred	
Division	il or Attending Patter death. I Director: After the fin by the funera	Ifica	3 Suicide 6 Could not determine	be 28e. Place of Inju	ry - At ho	ome, farm, stre						ural Route Number,
ā	To the Hospital or Attending within 24 hours after death. To tha Funaral Director: After completely filled in by the fune	Certification:	4 Hornicide	bullaing, etc.					City or To			
	ie Hosp 124 hou ia Funa ietely fii	edicai	29a. Certifier Certifying F	Physician: To the best of	examina	wledge, death tion and/or inv	occurred at the tir restigation, in my o	me, date and pla pinion, death o	ace, and due to the courred at the time,	cause(s date an) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To tha complet	Mec	29b. Signature and title of certifier	and manner stat	.54.		29c. Licens	e number		29d. Da	te signed (Mont	h, Day, Year)
	⊢s⊢ö		> /L 2	for 1	10)	172	518	7	6	124/0	5
	5		30. Name and address of person	completed cause of de	ath (Item	n 23a) (Type, I	Print) \		1 1	1	1	
	~~	•	31. Date filed (Month, Day, Year)	32. Registr	s Signa	ture /t 6	ne D	irunde	1 1/2	de	cc / (ontor
4.	Sta Registr		JUN 2	2 9 2005 ▶	CABLA	w St.	Sparke					

			1 - For Stete Registrar	State of Ma	aryland		artment			and M		giene	20105
			Decedent's Name (First, Middle, La	ist)				-			2. Date of Dea	ith - U	3. Time of Death
	Physici		Cecelia	Bern	adette		Newc	omb			Month July	1. 2005	10:15 P M
	/Medic Examir		4a. Facility Name (If not institution, gir						Location of	of Death	- ul	4c. County of	
			12503 Bedford Roa				C	umber	1and			Alleg	anv
	Funeral				e (In yrs. las	st birthday)	If Under	1 Year	If Under		8. Date of Birth	9	Birthplace (State or Foreign
	Director		217-10-4490	1□M 2∏F	88	Yrs.	Months	Days	Hours	Min.	(Month, Day 08/20/19	(Year)	ryland
	P _		Usual Residence of Decedent										
	show	_	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Ba-f	cto		egany			Cumber	land					1 ☐ Yes 2 📉 No
	ith th	Director	10e. Street and Number				10f. Zip	Code			1	10g. Citizen of Wha	it Country?
	ath w	ra	12503 Bedford B					215				USA	
	tems	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decede f Yes, speci	ent of His	spanic Origin, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Race Black. \	American Indian, White, etc.
36	be filed within 72 hours after death with the Maryland that Hyglene. ad other then "neturel", or Items 23a or 28a-1 show event, the Medical Exat are must be redified at	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 217 N	No		Yes 2	Mo	Specify:			Specify:	
0	hour turel	d b		Year or Dates:		10- 0	441111	10					White
5	" "ne	Completed	15. Decedent's E (Specify only highest gr			(Give	lent's Usual kind of worl DO NOT use	k done d	urina most	of worki	ng	16b. Kind of Busin	ess/Industry
12	withi ene. then	щć	Elementary/Secondary (0-12)	College (1-4or 5	i+)		nemaker	,				Homer	nokor
2	filed Hygi ther		17. Father's Name (First, Middle, Lasi)		1101	nemaker		18. Mothe	r's Name	(First, Middle	Maiden Sumame)	akei
Maryland 21215-0036	12 should be filed w n and Mental Hygie Is marked other t reumatic event, II.	o Be	William	John	Win	field			Mar		Anna		Himmer
<u></u>	ges 1 and 2 should it of Health and Mer If item 27 is marke or other treumatic	2	19a. Informant's Name/Relationship	Type, Print)			a Address	(Street a				r, City or Town, Sta	
S	and 2:		JoAnn Greise / daug	hter								d, Maryland	
<u>6</u>	Hea Hea tem tem		20a. Method of Disposition	, ileer	20b. Plac	e of Dispo	sition /Nam	e of				20c. Location - City	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other trei		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			-	natory or oth	•	. !				
ቜ	artme orten injur	- 17	21. Signature Fun ral Service Lice		Hi L		Memori					Cumberlan y Funeral H	id, Maryland
Ba	Depariming Department of the series of the s	. 19	di de	Code		1					•	, Maryland	
			23a. Part1. Enter the disease, or com	plications that caused	the death.								Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ne.	0-	1	101	001	n.		,	Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)	acndst	Hge	RO	nal	CO	4 (In	cer		640V
Н	Examiner			Due to (or as	a conseque	nce or):							
		ē	Sequentially list conditions, the state of the cause. Enter Underlying Cause (Disease or injury	b. Dille to (Scas)	n consecuer	tele offr	-						=
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8760,	cate be executed obysician and the burial-transit	dicai		d									
မ	ifficat g phy as th	a ·										12	
Вох	eath certific attending p I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of	delivery
	death e atte	icia	in the past 12 months?	1 □ Live birth 4 □ Pregnant at			Ectopic pre Other (spe					Month	Day Year
O.	that the deed by the detached	hys	9 🗌 Unknown	9□ Unknown									
٣.	The law requires that the death certific ate has been signed by the attending p age 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to death bu	ut not resulti	ng in the ur	derlying ca	use givei	n in Part I.		23e. Did tot	bacco use contribut	te to the cause of death?
Ď	w require been sig should b	edt									1 □ Y∈	es 2 No 3	Probably 4 Dunknown
Records,	aw requas been 2 should	Completed									24a. Was a		autopsy findings available
	The lar	E									autops perform	ned? deat	to completion of cause of h? Yes 2□ No
Vital		O	25. Was case referred to medical						26. Place	of Death	(Check only on		165 2 100
<u> </u>	ysicien: is certific director,	O.B	examiner? 1 □ Yes 2 ⊅ No	Hospital:	nt 2 EP	VOutpatient	3 DOA	Other	~		ne 5 Reside		Specify)
Division of	Attending Physicien: r death. sctor: After this certifici	T:U	27. Manner of Death	28a. Date of Injur (Month, Day	y Yearl 28	Bb. Time of Injury		c. Injury Work	at			ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
<u>o</u>	ttendin death. ctor: Afi / the fur	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	7007	Hijaty	M		es 2 🗆 N	10			
<u> </u>		tific	3 Suicide 6 Could not b		ry - At home	e, farm, stre	et, factory,	office		2	8f. Location (St. City or Town		r Rural Route Number,
	tel or A	Certification:		Daniang, oto	(opcomy)					t	Oily Gr 70mi	i, otatoj	
	Hospite 24 hours Funerel etely filled		29a. Certifier 1 Certifying Pt	nysicien: To the best of	of my knowle	dge, death	occurred a	t the time	, date and	place, a	nd due to the ca	ause(s) and manne	r as stated.
	To the Hospitel or within 24 hours afte To the Funerel Dirr completely filled in I	Medicai	5/10)	niner: On the basis of and manner sta	ted.	- and of 1/1V	osugation, I	п пу орг	mon, death	occurre	a a use ume, da	ate and place, and	and to the cause(s)
	To the within To the comple	2	29b. Signature and title of certifier	1/200	0 .	W	29c.	License	number	0	25	9d. Date signed (M	onth, Day, Year)
;	4		1///	1649011	ww			12	21	21		Julv 5	5. 2005
	_ ·		30. Name and address of person who				·						
	nos		Gary L. Wagon	00 4	4. 01			ve, (Cumber	land,	Maryland	21502	
	Sta		31. Date filed (Month, Day, Year)	05 32 degistra	r's Signatur	La	retes						
	Registr	aii	JUL 0 5 20	IUJ JUSTINE	مراكز م	MI	-						

	1	For State Registrar	State of M	aryland		irtment (<i>tificate</i>			Menta		ene 3. No.2 () (15	23120
Physicia	25	1. Decedent's Name (First, Middle, Last							Mon	of Death	Day	Yeer	3. Time of Death
/Medica	al -		ller			4b City To	was or L	ocation of Dea		e 24,	4c. County o	f Death	12:15 A M
Examine	er '	4a. Facility Name (<i>If not institution, give</i> 227 5th Stree					thia		201		Anne A		el
Funeral Director	:	5. Social Security Number 6. Se 1237–38–8302	x 7. Ag	ge (In yrs. Ia 75	as <i>t birthday)</i> Yrs.	If Under 1 Months		If Under 24 Hr Hours Mir	8. Date	of Birth	1930	9. Birthp Cour N	lace (State or Foreign try)
3	-	Usual Residence of Decedent		10a City	, Town or Lo	antina						1	0d. Inside City Limits
fines of the state	.	10a. State 10b. County MD Anne Aru	ındel		othian								1 ☐ Yes 2 No
28a-f	Director	10e. Street and Number				10f. Zip C	ode			10	g. Citizen of WI	hat Cour	ntry?
3a or		227 5th Street					20	711			US	A	
at of Health and Mental Hygiene. If Itlem 27 is marked other than "natural", or Items 23s or 28s-1 show or other traumatic event, the Mexical Examinar must be nutilised at	ב ב	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give	?	1	Was Deceder f Yes, specify 1 ☐ Yes 25		panic Origin? (Mexican, Pue Specify:	(Specify Yes erto Rican, e	or No-		, White,	ean Indian, etc. hite
ural;	od by	3 XWidowed 4 □ Divorced	Year or Dates:		16a Decer	dent's Usual (Occupati	00		1	6b. Kind of Bus		
than "nat	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		5+)	(Give life. I	kind of work DO NOT use Hostes	done dui retired)	ring most of w	rorking			taur	,
Hygie other		17. Father's Name (First, Middle, Last)				1105 (65		8. Mother's N	ame (First, i	Middle, M	aiden Sumame		airt
Mental arked o	To Be	George H. Can	mpbell					Kath	leen			V	oliva
and N	- 7	19a. Informant's Name/Relationship (7)			1	_					City or Town, S	itate, Zip	Code)
Department of Health a Important: If Item 27 is sny injury or other tra once.	8-	Julie Ann Kidwell 20a. Method of Disposition	(sister)	20h. Pl		ain St			ian, I		20711 Oc. Location - C	City or To	own. State
i if ite		1 ☐ Burial 2 ☑ Cremation 3 ☐		er i	metery, crer e Crem	sition (Name natory or othe	er place)	่างเม	ne 27		Clinto		
njury	t	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service License		Tee		•	Address		2005 ce Fui	neral			ert. PA
any in		. / /	OFF					n Mary					
Assician and busician and busician and busician and see as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a: Due to (or a: Due to (or a:	s a consequ	Converse of):	ev							
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and and	by Ph	Part II. Other significant conditions of	ontributing to death	but not resu	ulting in the u	nderlying cau	ise given	in Part I.	236		-		he cause of death?
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ate has page 2	Completed								-	a. Was an autopsy perform] Yes 2	ed2 pr	rior to co	ppsy findings availab impletion of cause of 2 No
£ 5	Be	25. Was case referred to medical examiner?	Hospital:				Other	26. Place of D		/			
this di	P.	1 Yes 2 No 27. Menner of Death	1 🗀 Inpai		ER/Outpaties 28b. Time o		c. Injury	4 Nursing			nce 6 ⊡Othe w injury occurre		(y)
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within 24 hours after de To the Funeral Directo completely filled in by th	edical Ce		ysician: To the bes niner: On the basis and manner:	of examinat									
within 2 To the comple	Med	29b. Signature and title of certifier		,		29c.	License	number	7	29	d. Date signed	(Month,	Day, Year)
, - 0		· malin'	7840	۲.			D	177	174		6,2	7/2	25
10		30. Name and address of person who Mahin Yazdani		death (Item 2555 S	23a) (Type.	Print) ns Isl	and	Road 1	Huntir	ngtow	n, MD	206	39
Sta	te	31. Date filed (Month, Day, Year)		tras Signa	ture	May	4.2						

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KNAKU	ion

			1 - For State Registrar	State of	iviai ytai		rtificate of	Death	ieritai i iy	Reg. No.2	005	23127
	Physici		Decedent's Name (First, Middle, Rozpaze	Last) I Zachary	Pilker	rton			2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution,			LOII	4b. City, Town, o	r Location of Death	JULY	04 4c. C	2005 ounty of Deat	1 4:34 a "
	Examin	ęr	St. Mary's Hos		•		Leonard			Sai	nt Mar	v¹s
	Funeral			. Sex 7	. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th		hplace (State or Foreign untry)
	Director		217-34-1630 Usual Residence of Decedent	1 M 2 □ F		68 Yrs.	Months Days	Hours Min.	March 16		Mar	yland
	anyland show	Ŀ.	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8e-f	Director	Maryland Saint M	ary's	Me	chanics						
	vith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Co	untry?
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920	72 hours after death with the Maryland "neturel", or Items 23s or 28e-f show offed Examiner out be notilled at	by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 X Yes 2 If Yes, Give Year or Dat	ces? 2 □ No		was Decedent of F If Yes, specify Cub: 1 ☐ Yes 2 ☒ No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	Pican, etc.)		Black, White pecify: Wh	e, etc.
0-10	72 ho	ted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Occup	pation during most of works	ina	16b. Kind	of Business/	Industry
Maryland 21215-0036	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use retired Manager	d) most of worki	ng	Sand	& Grave	l Company
d 2	filled Hygir other	e C	17. Father's Name (First, Middle, L.	ist)		Iaits	namager	18. Mother's Name	(First, Middle			1 Company
lan	td be ental ked c	To B	Martin Leonard Pil	kerton				Cora Eliza	beth Mors	zan		
ary	2 should be f and Mental b is marked of eumetic eve	-	19a. Informant's Name/Relationshi			19b. Maili	ng Address (Street	and Number or Rura	`		Town, State, 2	Zip Code)
	12 mg		Hazel Lorraine Pilke	rton / Wife		27110	Mechanicsvi	lle Road, M	echanics	ville,	Marylan	d 20659
Jre,	es 1 an of Heal f item 2 rr other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	Domewal from C	20b. F	Place of Dispo cemetery, crea	osition (Name of matory or other place	ce)	Date	20c. Loca	ation - City or	Town, State
Ē	Pages nent of I ant: If it		'4 □Donation 5 □Other (Spe			James C	emetery	July 7	, 2005	Dameron	n, Maryl	and
Baltimore,	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral	censee		Ma	2. Name and Addre ttingley-Ga	ess of Facility ordiner Fune: Leonardtown	ral Home.	, P.A.	50	
			23a. Part . Enter the disease, or c shock, or heart failure. List o	omplications that ca	used the deat							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Col y	FAMI NA	L E				DAVI
	/Medical		resulting in death)	a. Due to (c	r as a consec	juence of):	FALLUR					
и	Examiner		Conventingly, list conditions	LUI	VG .	CANC	ER					MONTHS
	P #	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to [c	ras a consec	ruence of):						
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec	uloppo of):						
60,	icate be executed physician and s the burial-transit		,	000 10 (0	11 as a corisec	juerice orj.						
68760,	physicate sthe	Medical		d								
.O. Box (Hospitel or Attending Physicien: The law requires that the death certificate be executed 4 hours after death. Funerel Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Feta int at time of c	I death 3	□Ectopic pregnanc; □ Other (specify) _	у		230	d. Date of del Month	ivery Day Year
<u>α</u>	that the poly detail	y Ph	Part II. Other significant condition	s contributing to dea	ath but not res	ulting in the u				obacco use	e contribute to	the cause of death?
sp	uires sign ld be	d by	CHIPONIC OR	STRUCTIL	IE P	ULMON	VARY	DISEASE	1 🗁	Yes 2	No 3□Pr	obably 4 Unknown
Records,	w requires been signal	Completed		,					24a. Was		24b. Were au	topsy findings available
Re	The lav te has age 2	omp							auto perfo 1 ☐ Yes	psy ormed? 2 4 No	death?	completion of cause of 2 No
Vital	ystcien: The is certificate hadirector, page	a	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·			26. Place of Death			7 (103	2010
<u>></u>	yslci is cer direc	O B	examiner? 1 Tes 2 Mo	Hospital: 1 ☐ In	patient 21	ER/Outpatie	nt 3 DOA Oth	ner: 4 Nursing Ho	me 5 Resi	dence 6[Other (Spe	cify)
n of	ding Ph h. After th funeral	on: T	27. Manner of Death 1 Natural 5 Pending		l Injury , Day Year)	28b. Time o	f 28c. Injui	ry at rk?	28d. Describe			
sio	death. death. ctor: A / the fu	cat	2 Accident investigated and Suicide 6 Could no	t he	of Initial At h			Yes 2 □ No	29f Location /	Stroot and I	Numbos os Pi	ıral Route Number,
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2	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the l xaminer: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and place, opinion, death occurr	and due to the ed at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens				signed (Monti	-
			1 / Cri			MD	D	56096		7.5	: O :	
			30. Name and address of person w	ho completed cause	of death (Iter	п 23а) (Туре,	Print)					
			RAJBINDER S GI		ASSOC H		OOD MD 2	0636				
	Sta Registi		31. Date filed (Month, Day, Year) JUL 0 6	2005	gistrar's Signa	B A	nerth					

		1 - State of N		artment of Health and rtificate of Death	-	ene	
Physic	an	1. Decedent's Name (First, Middle, Last) EDGAR LYSTON PYLE,	JR.		2. Date of Death Month JUNE 2	Day Year	Trop of Delay 8
/Medi		4a. Fecility Name (If not institution, give street and number		4b. City, Town, or Location of Dea		4c. County of Death	1:40 A ^M
Exami	ier	CORSICA HILLS NURSING CEN	TER	CENTREVILLE If Under 1 Year If Under 24 Hr		QUEEN AND	NE'S
Funeral Director	h	1 MM 2 DE	ge (In yrs. last birthday) Yrs.	Months Days Hours Mir		1924 MAR	place (State or Foreign intry) YLAND
land wo		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
Mary -f she	to	MD QUEEN ANNE'S	CHESTER				1 ☐ Yes 2 No
the note	Director	10e. Street and Number	CHESTER	10f. Zip Code	10	g. Citizen of What Cou	intry?
3a of		2603 HARRINGTON ROAD		21619		USA	
death ms 2	ner	11. Marital Status 12. Was Deceden	t Ever in U.S. 13.	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Amer	
6 after	by Funeral	Armed Forces 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ If Yes, Give	No	f Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 🛣 No Specify:	no Pican, etc.)	Black, White	, etc.
5-0036 72 hours after death with the Maryland natural', or Items 23a or 28s-1 show dieal Examiner out the notified at	db	3 ☐ Widowed 4 ☐ Divorced Year or Dates		TO THE S ZIMENO SPECITY.		Specify: WH	ITE
21215-0036 d within 72 hours at giene. er than "natural", or the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of wo	orking	6b. Kind of Business/I	ndustry
within ene.	d L	Elementary/Secondary (0-12) College (1-4or -0-	5+) //fe. /	OO NOT use retired) AUDITOR		CTVII CEDV	I C E
d 2 filled v Hygie other i	e Co	17. Father's Name (First, Middle, Last)			ame (First, Middle, Ma	CIVIL SERV	LCE
Maryland 2121 d 2 should be filed within th and Mental Hygiene. ?? Is marked other than traumatic event, the Me	To Be	EDGAR L. PYLE, SR.			RA SHEETS		
Z 5 = 27 ± 12 €		19a. Informant's Name/Relationship (Type, Print) FRANCES CARTER PYLE / WIFE		ng Address (Street and Number or Fi HARRINGTON ROAD,			o Code)
Baltimore, North Pages 1 and Department of Health Important: If Item 27 in yighty or other the 2006.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	9	sition (Name of natory or other place) LE CEMETERY 07/(STEVENSVI	
Baltimor permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Licensee	22	. Name and Address of Facility	25 1 1		
# 403.44		23a. Part1. Enter the disease, or complications that cause		LLOWS, HELFENBÍEN 6 SHAMROCK ROAD,			
		snock, or near failure. List only one cause on each	line.			it,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	rcreatic	cancel			
Examiner		Due to (or a	s a consequence of):	Jery Desea	10		
01	ē	Sequentially list conditions. If any, leading to immediate b. Due to (or a	s a consequence of):	yes proce			
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8760, cate be excohysician at the burial	dical	d					
death certificate be executed death certificate be executed e attending physician and dor use as the burial-transit	led					15.75	
Box 6	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom 1 □ I ive birth		Ectopic pregnancy		23d. Date of deliv	
O. El le deat the att hed for	sicie	1 Yes 2 No		Other (specify)		Month	Day Year
P.O. that the ded by the detached	Phy	9 Unknown			- 100-0		
I Records, P.O. The law requires that the ste has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.		cco use contribute to t	
Records, he law requires the has been signed age 2 should be a	Completed	Diagram 1000	aj G		1 L Yes	2 No 3 Pro	pably 4 Unknown
Aec e law has b	nple	Uninay truet	infecto		24a. Was an autopsy	prior to co	ppsy findings available impletion of cause of
	ပိ	Cormer Vasula	u all	adent	performs	death?	2120
Vital Fisician: The sectificate	Be	25. Was case referred to medical examiner?		Othor \	eath (Check only one)		
of Vita Physician: rthis certific	P.	1 Yes 2 No 1 I Inpat 27. Manner of Death 28a. Date of Inj				ce 6 Other (Speci	ý)
ding h. After fune	ig	1 Natural 5 Pending (Month, D	ay Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division or Attending after death. Director: After	flca	3 Suicide 6 Could not be 28e. Place of Ir	njury - At home, farm, str		28I. Location (Stre	et and Number or Run	al Boute Number
Div A after I Direct	Certification:	4 Homicide determined 200. Flate of it building, a	tc. (Specify)	oo, tastory, onloo	City or Town,	State)	
Division of Vita No the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 12 Certifying Physician: To the besis and manner sand manners	of examination and/or inv	n occurred at the time, date and plac restigation, in my opinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner as s e and place, and due t	tated. to the cause(s)
o the o the omple	Mec	29b. Signature and hitle of certifier		29c. License number	290	d. Date signed (Month,	Dey, Year)
+ 3 + 5		Valerie awan	on Dio	· 16057821		6/27/0	5
		30, Name and address of person who completed cause of Valeric GODDIAN, 2540	death (Item 23a) (Type,		ille in	LD 216	17
St Regist	ate rar	31. Date filed (Month, Day, Year) 2 9 200532. Regi	rar's Signature	frede	. ,		

amend item#20b, perFH, C045, 714/05 TI
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 6 Day 26 **Physician** Robert Reed Pleasanton Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sunbridge Nursing Home Elkton Cecil | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12-26-23 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1XM 2□ F 81 221-12-9344 Yrs DE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No AR Izard Melbourne **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PO Box 846 72556 U.S. 12. Was Decedent Ever in U.S. Agned Forces? 12 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White Be Completed by 3 ☐ Widowed 4 ☼ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dary Farmer Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Pleasanton Viola Marker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert R. Pleasanton Jr. 1405 Middleneck Rd. Warwick, MD 21912 20b. Place of Disposition (Name of cemetery, crematory or other place)

Capitol Crematory 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Dover * 4 ☐ Donation 5 ☐ Other (Specify) MO-1375 Paniels & Hutchison FH 21. Signature of Funeral Service Licensee Karl Maurice 19709 N. Broad St. Middletown, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) unknown Cerebrovascular Due to for as a consequence of): mson's diseas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atherosclososis Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 100 1 ☐ Yes 1 ☐ Yes 2 17 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

723322

29d. Date signed (Month, Day, Year)

ECETIM MD 21921

6,28,05

Examiner Examine attending physician and for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Vital Records, P.O. Box 68760, Physician/Medical à Completed has certificate this After this funeral of Certification: death. Director: within 24 hours after d To the Funeral Direct completely filled in by filled in by

Funeral

Director

r then "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at

other then "

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, importent: if item 27 is marked othe any injury or other traumatic event, once.

Pnysician

/Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

8+IVA

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

29a. Certifier

Medical



JUN 2 9 2005

Jackders MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Stella Pietrykowski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Worcester Berlin 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 13, 1934 9. Birthplace (State or Foreign PA 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2**X**F 159-30-1406 70 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or than "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at Be Completed by Funeral Director MD 1 Yes 2 No Worcester Ocean Pines 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 42 Hatteras St. 21811 USA Pages 1 and 2 should be filed within 72 hours after death vanet of Health and Mental Hygiene.
sant: If item 27 Is marked other than "naturel", or Items 23 and it is not other treumatic event, it is Medical Expans are must 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 1 Never Married XX Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify White 1 Yes Z No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John A. Chiado Mary Boggett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Pietrykowski 42 Hatteras St., Ocean Pines, Md. 21811 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 7-5-05 Freeport, PA * 4 □Donation 5 □ Other (Specify) 21. Si nature of Funeral Sapris Livensee 22. Name and Address of Facility The Burbage Funeral Home M00284 108 William St., Berlin, Md. 21811 23a. 2art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) DNUMONIC /Medical Du to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): cho a Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Anpatient 임 2 ER/Outpatient 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of

ietrykowski, Stella or Attending Physicien: 15a Division death. within 24 hours after deat To the Funerel Director:

Registrar

Certification:

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kobert

5 Pending

investigation

6 Could not be determined

31. Date filed (Month, Day, Year) 0 2005

Dulle

32. P

M51611

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

State of Maryland / Department of Health and Mental Hygiene

					Olale of I	viai yiai	-			Death	Mortarity	Reg. No	0=	
			1. Decedent's Name (Firs	t, Middle, Las	it)						2. Date of De	eath C	05	Z Time of Death
	Physic		Almeda			Poo	le				July	3. 20	Year 05	10:40 AM
	/Medi Examir		4a Facility Name (If not in	stitution, give	street and number					4b. City, Town, or			ty of Death	
	Xuiiiii		Devlin Ma	nor Nurs	sing Home					Cumber1	and		Allega	nv
	Funeral		5. Social Security Number	6. S	ex 7	Age (In yrs.	last birthday		ler 1 Year	If Under 24 Hrs	8. Date of Bi			place (State or Foreign ntry)
	Director		214-05-7304	1	□М 2∏ДЕ	87	Yrs.	Month	s Days	Hours Min	05/08/19		1	ylvania
	D	'	Usual Residence of Dece	dent							1 0.27 007 1	7.1.0	Tems	yivania
	rytar Phow		10a. State 10b.	County		10c. Cit	ty, Town or I	ocation						10d. Inside City Limits
	e Wa	cto	MD	Alle	gany		Cu	mber1	and					1 No 2 No
	計 6.28	Ë	10e. Street and Number					10f. 2	Zip Code			10g. Citizen of	What Cou	ntry?
	th w 23a	by Funeral Director	1808 Bedf	ord Str	eet					21502		US	SA	
	dea	ne	11. Marital Status		12. Was Deceder Armed Force	nt Ever in U	,S. 13	Was Dec	edent of I	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No)- 14. Ra	ce - Ameri	
0	or it	5	1 Never Married 2		1 ☐ Yes 2 ☐ If Yes, Give				2 ∰ No		to Thour, oto.,		ack, White,	etc.
8	ours	9	3 ☑ Widowed 4 □ D	ivorced	Year or Date:	s:		100	-77.110			Spec		Mhite
5-	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f ahow aumatic event, the Mactical Examiner must be notified at	Be Completed	15. D (Specify onl)	ecedent's Ed highest grad	ucation de completed)		16a. Dec	edent's Us	sual Occup	pation during most of wo d)	rking	16b. Kind of I	Business/In	dustry
12	ithin Pe	Ē	Elementary/Secondary	(0-12)	College (1-4c	r 5+)	life.			d)				
3	ygier ygier it,	Ö	12					Homem	aker				lomemak	er
ī	d off	Be	17. Father's Name (First,)	Middle, Last)	77.11.		17				me (First, Middle		,	
∑ Ş	ould Men arke	2	Sylvester		Willia	n 	1	mkle		Ella		Im]		
Baltimore, Maryland 21215-0020	es 1 and 2 should be filed within of Health and Mental Hygiene. I filem 27 ia marked other than w other traumatic event, the Me		19a. Informant's Name/Re	elationship (7	ype, Print)		19b. Mai	ling Addre	ss (Street	and Number or R	ural Route Numb	er, City or Tow	n, State, Zip	Code)
4)	and lealth m 27 her t		Sandra Groves		hter	1				cive, N.E.,				
ō	ges 1 t of h If ite or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crer		Removal from Stat		Place of Disp cemetery, cr	ematory of	ame or rother pla	се)	Date	20c. Location	- City or To	own, State
Ë	permit. Pages Department of H Important: If Ite any injury or of		4 ☐ Donation 5 ☐ O	ther (Specify)	Sur	iset Mer				06/2005			laryland
al	permit. Departr Imports any inju		21. Signature of Funeral S	Service Licen:	ee a			22. Name	and Addre	ess of Facility Ac	lams Famil	y Funeral	Home,	P.A.
ш	0.0 E 8 8		Lake	1	& Cie	an		404	Decat	ur Street,	Cumberla	nd, Maryl	Land 2	1502
			23a. Part1. Enter the dise shock, or heart failur	ase, or comp	lications that caus	ed the deat	h. Do not er	nter the mo	ode of dyir	ng, such as cardia	c or respiratory a	rrest,	į.	Approximate Interval Between
	Physician		oncon, or near range	o. Liot offiny c	THE GRADE OF GRADE	iii to.							1	Onset and Death
1	/Medical		Immediate Cause (Final disease or condition				100	17		. O.			1	10 yr
	Examiner		disease or condition resulting in death)		a	Due to (c	or as a conse			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				η_
	D €	Examiner		_	_								i	
	requires that the death certificate be executed een signed by the attending physician end hould be deteched for use as the buriel-transit	ше	Sequentially list condition	s, (D	Due to (o	ras a conse	quence of	·):				1	
68760,	e exe	<u> </u>	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	te .									i I	
876	ate b hysic the b	edical	that initiated events resulting in death) Last		C	Due to (o	r as a conse	quence of):				1	
6	e as	>		L	d									
Box	eath cert attendin for use	an/			d	-								
	e des he at	Physiclan/	Part II. Othar significant o					underlying	cause giv	en in Part I.	23b. Did	tobacco usa c	ontributa to	tha causa of death?
P.0	at the	된		2 U /	-						1 🗆	Yes 2 No	3 🗌 Prol	bably 4 ☐ Unknown
	res that the designed by the a	by			*									
oro	v require been sig should t	Completed		stren	l fran	lota					24a. Was perfo	an autopsy rmed?	ava	ere autopsy findings allable prior to
eC	aw 2 S	be			1								of	mpletion of cause death?
Œ.	0 - 0	Ö									10	Yes 2 Hin	10]Yes 2□No
'ita	ician: The certificate rector, pag	Be (25. Was case referred to r examiner?	nedical						26. Place of Dea	ath (Check only o	one)		
Division of Vital Records,	G 15	2	1 ☐ Yes 2 ☐ No	!	Hospital: 1 ☐ Inpa	tient 2	ER/Outpatie	ent 3□ D	Oth Oth	er: 4⊟nursing H	lome 5 ☐ Resi	dence 6 🗆 Ot	her (Specif	y)
0	ig Ph ter th neral	Ë	27. Manner of Death 1. □Natural 5 □	Pending	28a. Date of In (Month, D	jury av Year)	28b. Time	of	28c. injur Wor	y at k?		how injury occu		
io Si	auth. or: Af he fu	atic	2 Accident	investigation				M		Yes 2 □ No				
ž	er de recto	Ĕ	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of I	njury - At ho	ome, farm, s	treet, facto	ry, office		28f. Location (S City or Tox		ber or Rura	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:				. , ==//	-							
	d hou uner uner	edical	(Check only 2 M	adical Exami	sician: To the bes nar: On the basis	of examinat	ion and/or in	rvestigatio	n. in my o	pinion, death occur	rred at the time	date and place	anner as st	ated.
	the 1				and manner	stated.	J. J. J. J. J. J. J. J. J. J. J. J. J. J	- Janguno	,			and place,		
	5. ¥ 5. 20°	Σ	29b. Signature and title of	certifier	2 41			29	c. Licens	e number	1	29d. Date sign		
	5		7	ysec	יותר יותר				1)	0 / /3 6	4	July 3	260	3
	5 / 1		30. Name and address of	erson who c	ompleted cause of	death (Item	23a) (Type	, Print)			5.			
	nds		AJB	Ilino	(11) 92	1 K	171	HU	7	L21210	114	11506		
	Sta Registr	te	31. Date filed (Month, Day	5 200	and manner s	trar's Signa	ture	ark						

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** BAILEY ANDREW REDDEN 06 25 2005 /Medical 00:25 4b. City. Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL 6. Sex 1**X** M 2□ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 06/21/2005 MD Usuel Residence of Decedent Pages 1 and 2 should be filad within 72 hours aftar deeth with the Maryland nant of Health end Mentai Hyglana. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or items 23s or 28e-f shorminer must be notified at 1 ☐ Yes 2 X No Director QUEEN ANNE'S STEVENSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 412 BEACHSIDE DRIVE 21666 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health end Mentai Hyglana. Item 27 le marked other than other treumatic event, the M Elementery/Secondary (0-12) College (1-4or 5+) NONE NONE N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KENNETH ALAN REDDEN JAMIE ANN TIPPINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KENNETH REDDEN 412 BEACHSIDE DRIVE STEVENSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Depertment of important: if Its eny Injury or o bace. CHESAPEAKE CREMATION CENTER, LLC STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Service License 106 SHAMROCK ROAD CHESTER, MD. 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 Yes No Tematom Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA this 27. Manner of D 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred edicai Certification: 1 Natural 2 Accident 5 Pending investigation Within 24 hours after death.

To the Funerei Director: Aftr 1 ☐ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47158 June 25, MID erson who completed cause of death (Item 23a) (Type, Print) Yann Lin , M.D 31. Date filed (Month, Day) 32. Regimar's Signature State Registrar

				For State Registrar	State of M		nd / Depa	artme	nt of H	. Ensure A Health and I Death	Mental Hy	giene	05	23133
		Physici		1. Decedent's Name (First, Middle, La: Myrtle Viola							2. Date of Dea Month	ath Day	Year 2 005	3. Time of Death
		/Medic Examin		4a. Facility Name (If not institution, give	e street and number			4b. City		or Location of Death		4c. Count	ty of Death	1
		Funeral		THE MEMORIAL 5. Social Security Number 6. S	iex 7. A		. last birthday)	If Unde	er 1 Year	If Under 24 Hrs Hours Min.	8. Date of Birt	h		BOT place (State or Foreign Intry)
1		Director		220-28-0066 Usual Residence of Decedent	□ M 2 💢 F	72	Yrs.	Morturs	Days	Hours Will.	Nov. 11			ryland
0	P	Marylan a-f show	tor	MD 10b. County Dorch	ester	10c. C	îty, Town or Lo	cation	Camb	oridge				10d. Inside City Limits 1 Yes 2 □ No
9.	Ž .	with the a or 28, be not	Funeral Director	10e. Street and Number 2480 Cambridge	Poltway.			10f. Z	ip Code	21613		10g. Citizen of		untry?
- 1	6	after death w or ltems 23a miner must b	neral	11. Marital Status	12. Was Deceden	t Ever in l	J.S. 13.	Was Dec	edent of I	dispanic Origin? (S an, Mexican, Puer	pecify Yes or No-			ican Indian,
37.	036	be filed within 72 hours after death with the Maryland that Hygiene. Independent then "naturel", or liems 23a or 28a-f show event, the Medical Evantrar must be routined at	by	1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give * Year or Dates	No		ii res, sp 1 ☐ Yes		Specify:	to nican, etc.)	Spec	ack, White	nite
GGINS, MYRT	215-0036	hin 72 ho a. "natur Medicul	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-40)	(5+)	16a. Dece (Give life.	dent's Us kind of w DO NOT	ork done	during most of wo	rking	16b. Kind of I	3usiness/l	ndustry
E	21	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then eny injury or other treumatic event, Item 2006.		7				pr	essei			garm		
35,	Maryland	d be fi	o Be	17. Father's Name (First, Middle, Last, Samuel Oliver Bo						11122	me (First, Middle, gie R. C		me)	
Y.	aryl	shoul and Me s mark umati	Ĕ	19a. Informant's Name/Relationship (19b. Mailir	ng Addres	ss (Street	and Number or Ru			7, State, Z	îp Code)
દુ		and 2 ealth a m 27 to		Ritchie Riggins	husb		2480	Caml	orid	je Beltwa				1613
Ä	Baltimore,	ages 1 of H or of H or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □		0	Place of Dispo cemetery, crea				Date	20c. Location		
•	altin	artmer artmer ortent injury		'4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Licer		Dor				al Park 6	/28/05 homas Fu	Cambr:		
	ñ	permi Depar Impor eny ir		I fh vo len	~					st St.,Ca			1613	r.A.
		Physician /Medical Examiner	ər	23a. Pa.M. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate		s a conse	U Co. Guence of): Se mail			ng, such as cardial Lin Leir		rest,		Approximate Interval Between Onset and Death
	38760,	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a									
	P.O. Box 68	To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fel at time of	tal déath 3[]Ectopic] Other (s		у			ate of deliv	very Day Year
		uires that the de signed by the a Id be detached f	by	Part II. Other significant conditions	contributing to death	but not re	sulting in the u	nderlying	cause gn	ven in Part I.				the cause of death?
	COL	aw requir as been si 2 should	Completed						-		24a. Was		. Were au	opsy findings available
	l Re	icien: The lav certificate has rector, page 2	Comp									med? 2⊠No	prior to c death? 1 \(\subseteq \text{Yes}	ompletion of cause of 2 No
	/ita	icien: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				04		ath (Check only o	ne)		
	of	Phye	T: To	1 Yes 2 No 27. Manner of Death	28a. Date of In (Month, D		ER/Outpatier		28c. Injui	ry at	lome 5 Resid			ify)
	ion	ath. rr: Afte	atlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	Jay Year)	Injury	М	Wo	rk?]Yes 2 ☐ No				
	Division of Vital Records,	al or Atte s after des l Directo	Certification:	3 Suicide 6 Could not be determined	288. Place of I	njury - At etc. <i>(Spec</i>	home, farm, str efy)	reet, facto	ry, office		28f. Location (5 City or Tow	Street and Num yn, State)	iber or Rui	ral Route Number,
		To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exal	hysician: To the bes miner: On the basis and manner	of examir	nowledge, deat nation and/or in	h occurre	d at the ti	me, date and place opinion, death occu	e, and due to the curred at the time,	cause(s) and n date and place	nanner as , and due	stated. to the cause(s)
4		To th withir To th	Me	29b. Signature and title of certifie	1 MD			2	9c. Licens	se number 057657	,	29d. Date sign	ed (Month	, Day, Year)
				30. Name and address of person who		f death (Ite	em 23a) (Type,	Print)	24	ST. P.	manis	Olie	mn	- 2/6/3
		- C+-	ate	MG HAM M AT	32. Regi			ICOT		11 08.	11/15/1011	40		-1015
		Regist		JUN 2	7 2005	2-2-0	a All		A. In					

			1 - For State Registrer	tate of Mary	-	artment rtificate			and M	lental Hy	/gien Reg. N		5	231	34
	Physici	an	Decedent's Name (First, Middle, Last)							June 2		ayoor	Year	3. Time o	
	/Media	cal	Edward Robert	ot and number)		4h Oile 7	Tau	Lanation	(Death	June 2			-10- "	6:15	Рм
	Examir	ner	4a. Facility Name (If not institution, give stre 106 Locust Drive	et and number)			rmon	Location o	of Death		4	c. County o Fre	or Death deri	ck	
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under	1 Year	If Under 2		8. Date of Bi	rth			place (State ontry)	or Foreign
	Director		407-42-7129	2DF 78	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D Oct. 2	<i>ау, Үөаг</i> 9 . 1	926	Texa	as	
	and *		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation							1	0d. Inside C	its Limite
	Maryl f sho	ō	Maryland Frederick		•	urmont	t						'		2 No
	r 28e	Director	10e. Street and Number			10f. Zip					10g. C	itizen of W	/hat Cour	ntry?	
	th wit	a D	106 Locust Drive				217	88				Uni	ted	States	S
	tems rrm	Funeral		Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decede	ent of His	spanic Orig	gin? (Spe , Puerto I	ecify Yes or N Rican, etc.)	0~		- Americ	an Indian,	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give 194 Year or Dates:	45-	1 ☐ Yes 2		Specify:				Specify:	T 74		
9	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show Jisal Exandrat must be colified at	ted	15. Decedent's Educati	on	1969 16a. Dece	dent's Usuai	l Occupa	tion			16b. I	Kind of Bus	siness/In	dustry	
215	within 7 ene. than "n	Completed	(Specify only highest grade co	College (1-4or 5+)	(Give	kind of work DO NOT use	k done d e retired)	uring most	of worki	ng				,	
21	filed wi Hygien ther th		12		Non-C	Commis	sion					S. Ar			
Maryland 21215-0036	d tal	Be	17. Father's Name (First, Middle, Last) Rupert Emmett Rober	+						(First, Middle n Aller		n Surname)		
Z	should nd Men marke umatic	2	19a. Informant's Name/Relationship (Type,		19b. Maili	na Address	(Street a			I Route Numb		or Town S	State Zir	Code)	
	1 and 2 Health ar iem 27 is		Audrey Robert / Wife	2						mont, N	-			0000)	
Baltimore,	ges 1 and 2 it of Health if Item 27 or other tr		20a. Method of Disposition 1X⊠ Burial 2 ☐ Cremation 3 ☐ Rem	oval from State	Db. Place of Dispo cemetery, crei	sition (Name	e of her place) Т		ate	20c. l	ocation - (City or To	wn, State	
Ë	Pag nent int: I		* 4 □Donation 5 □Other (Specify)	Oval II OIII State	esthaven			1.0	uly 2		Fred	lericl	k, M	arylan	d
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funer Service Lin		Re	2. Name and esthav	Address en F	of Facility unera	al Se	ervices	, S	kkot	Cody	P.A.	
	40240		23a. Part1. Enter the disease, or complicat	ons that caused the						lwy. Fr		rick,	MD	21701 Approximat	
			shock, or heart failure. List only the commediate Cause (Final	ause on each line.			- 5	A .	Jardiayo	1 Tespiratory a	iiiesi,			Interval Bet Onset and I	ween
7	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a cor	10	one		-	n	ing				24.	
	Examiner		Sequentially list conditions b. —		,			l							
	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a cor	nsequence of):										
	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):										
8760,	e be e sician s buris			,	,-										
89	tificate t ig physi as the t	ledic	U												
Вох	eath certific attending p for use as	an/N	ZOD. Was decedent pregnant	If yes, outcome of pre		Ectopic pre	плапсу					23d. Date		,	
.O.	the at	Physiclan/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown		Other (spe						Mon	th	Day 1	Year
Ρ.	that the		Part II. Other significent conditions contrib	uting to death but not	t resulting in the u	nderlying car	use give	n in Part I		23e. Did 1	obacco	use contril	bute to th	e cause of d	leath?
of Vital Records,	uires signe	d by	COPD			indonying da	acc give							ably 4 □l	
00	w requir s been si should i	lete	HTN							24a. Was	an	24b. W	ere autoi	sy findings	available
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		BeC	25. Was case referred to medical examiner?					26. Place	of Death	1 ☐ Yes	2 Pc No on	5 10	7 163	2 140	
of V	hys his I dir	၉	1 ☐ Yes 2 ☐ No Hos	1 L Inpatient	2 ER/Outpatier		Other	r: 4 🗆 Nur	sing Hon	ne 5.⊒-Resi	dence	6 Other	r (Specify)	
	ting P	lon:		28a. Date of Injury (Month, Day Yea	28b. Time of Injury		c. Injury Work			8d. Describe	how inju	iry occurre	d		
Division	Attending in death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of Injury -	At home farm str	M eet factory		es 2□N	- 1	8f. Location (Street a	nd Numbe	r or Rum	l Route Num	her
Ο̈́	let or Attending Possible safter death. In Director: After tile of in by the funera	Certification;	4 Homicide determined	building, etc. (Sp	pecify)	oot, idotory,	011100			City or To			or Here	71001071417	001,
	To the Hospitel or A within 24 hours after To the Funeral Direction completely filled in by	edical C	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner	an: To the best of my On the basis of exar and manner stated.	knowledge, death nination and/or in	occurred at vestigation, i	t the time in my opi	e, date and inion, death	place, a	and due to the ed at the time,	cause(s	and man d place, ar	ner as st	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	/		29c.	License				29d. Da	ate signed	.)		
				1/	m	and a second	01	754	7			6/30	,/0.	1	
			30. Name and address of person who comp William Harper, M.		(Item 23a) (Type, homas Jo		Dr.	, Sui	te 1	.01 Fre	deri	ick,	MD 2	1702	
	Sta		31. Date filed (Month, Day, Year) JUN 3 0 200	32. Redistrar's S	-	1									
	Registr	ar	001100 0 201	A STORE OF THE	B A	COSC .	\$								

			1 - For State Registrar	State of Maryla	-	artment rtificate			nd M			005	23135
	Physici		Decedent's Name (First, Middle, Last, ELIZABETH J.	ROBINSON						2. Date of De	aath	′ 200Š ^{ea}	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or	Location of	f Death			County of De	
			Wilson Health Care	e Center				burg			N	lontgor	nery
	Funeral Director		376-03-1000	7 Tr	o Yrs.	Months Months	Year Days	If Under 2 Hours	Min.	8. Date of Bi	rth 6,19	9. E 15 Ma	Birthplace (State or Foreign Country) ryland
	ne Maryland 8a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Md • Montgome		City, Town or L	burg							10d. Inside City Limits 1∏Yes 2 ☐ No
	with the	Dire	10e. Street and Number			10f. Zip (•	izen of What	,
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examination and once.	by Funeral	301 Russell Ave 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	U.S. 13.	Was Decede If Yes, specif			in? (Spe Puerto	ecify Yes or No Rican, etc.)		14. Race - Al Black, W	merican Indian, hite, etc.
21215-0036	within 72 hor ane. than "natura na Medicul E	mpleted	15. Decedent's Edu (Specify only highest grad		(Give	edent's Usual e kind of work DO NOT use ewife	Occupa done di retired)	tion uring most	of worki	ing		ind of Busine	
aryland 2	uld be filed v Mental Hygie rrked other i	To Be Co	12 17. Father's Name (First, Middle, Last) Ernest S. Johnstor	1						(First, Middle	, Maiden	Sumame)	
Mar	nd 2 sho lith and I 27 is ma r traume		19a. Informant's Name/Relationship (7) Margaret E. Mercer	•						u Route Numb nta Goi			e, <i>Zip Cod</i> e) la 33950
altimore,	Pages 1 a nent of Her nt: If Item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	TOTAL STATE	Place of Disponentery, create of I			! •	June 200				or Town, State
Balti	permit. Departminimporta any inju		21. Signature of Funeral Service Licens		2	2. Name and	Address	s of Facility	De'	Vol Fur			Md. 20877
,160,	Physician // Medical Examiner tune private paragraph of the private transit tune transit tune private transit tune private tune tune tune tune tune tune tune tu	lical Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause of bach line.	equence of):			, .		or respiratory a			Approximate Interval Between Gnset and Death Months
P.O. Box 68	ne death certific the attending p hed for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic pre □ Other (spe						23d. Date of o	delivery Day Year
Ś	w requires that the been signed by should be detact	by	Part II. Other significant conditions con Renal in	ntributing to death but not	resulting in the u	underlying ca	use give	n in Part I.			tobacco L		to the cause of death? Probably 4 □Unknown
Vital Record	iclan: The law certificate has b rector, page 2 sl	e Completed	Chypertens, 25. Was case referred to medical	con As	Thms	etub	-ca-	ncl			psy ormed?/ 2 No	24b. Were prior to death	autopsy findings available o completion of cause of ? es 2 \sum No
	/sicla	0 8	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3□ DQA	Othe	_ /		ne 5 Res		6 Mother (S	necify)
Division of	Attending Physiclan: The sr death. rector: After this certificate his by the funeral director, page	ation: T	27. Mann r of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time o		c. Injury Work			28d. Describe			333319)
Divis	tal or Attendests after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st cify)	treet, factory,	office			28f. Location (City or To			Rural Route Number,
	To the Hospitel or ₱ within 24 hours after To the Funeral Dire completely filled in b	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kiner: On the basis of exam and manner stated.	nowledge, dea ination and/or ir	th occurred a nvestigation, i	t the time in my op	e, date and inion, deati	l place, a	and due to the ed at the time,	cause(s) date and	and manner I place, and d	as stated. ue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	ž.	1			number	-		1		nth, Day, Year)
1	1		ARobert De	rephre	and	, <	00	411	5		VE Z	ned	7,2005
	5			irschbach M.I	201		11 A	ve. G	Gaitl	nersbur	g, M	d. 208	77
	Sta Registr		31. Date filed (Month, Day, Year) JUN 29 20	37 Registrar's Sig	Inature A	aver							

4	For State Registrar	State o	of Marylar		artment of H		and M	lental H	ygiene Reg. No		22126
	1. Decedent's Name (First, Middle,	Last)	_					2. Date of D			3. Time of Death
an cal	George Was	shington	n Reid					06	21	2005	1:17p M
	4a. Facility Name (If not institution,	•			4b. City, Town, or		of Death			County of Death	
	Prince Georg 5. Social Security Number	e Medic	al Cer 7. Age (In yrs.		Chever	⊥ y If Under	24 Hrs.	8. Date of B		ince (
	577-50-3411 Usual Residence of Decedent	1 X M 2 ☐ F	66		Months Days	Hours	Min.	11/	15/38	B Was	nplace (State or Foreign unity) Shington, D
tor	10a. State 10b. County DC			ty, Town or Lo Vashin							10d. Inside City Limits 1 Yes 2 No
	10e. Street and Number			-	10f. Zip Code				10g. Citiz	zen of What Co	untry?
<u>a</u> [1661 Kramêr	St NE			200	19			Į	JSA	
Dy Fur	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	2⊠No ive		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Ori In, Mexican Specify:	gin? (Spe 1, Puerto	ecify Yes or N Rican, etc.)		14. Race - Amer Black, White Specify: B1	e, etc.
combiened	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College ((Give	dent's Usual Occupa kind of work done o DO NOT use retired Oundkee	during mosi I)	t of worki	ng		nd of Business/i	
lo be Co	12th 17. Father's Name (First, Middle, L Namon Rei					18. Mothe		<i>(First, Middl</i>			
	19a. Informant's Name/Relationsh				ng Address (Street a				-		
1		laughter			Teak C	t Te			-		
	20a. Method of Disposition 1 Burial 2 □ Cremation		State	cemetery, crei	sition (Name of matory or other plac	· _		ate /or		cation - City or 1 1dover	
	4 □ Donation 5 □ Other (Sp21. Signature of Funeral Service L		Я Па	36	Memori Nead Fu	s of Facilit	1 но	3/05 ome &	Crer	nation	Service ,DC 20011
dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Charles are a sequentially that initiated events resulting in death) Last	c. 1/	(or as a consec	quence of):	mer			•			
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live t	tcome of pregn birth 2 Teta nant at time of c	al death 3	Ectopic pregnancy Other (specify)				2	3d. Date of deli-	very Day Year
þ	Part II. Other significant condition	ns contributing to d	leath but not res	sulting in the u	nderlying cause give	en in Part I.			tobacco us		the cause of death?
Completed	<u> </u>								opsy formed?	prior to c death?	topsy findings available ompletion of cause of
Be	25. Was case referred to medical examiner?		/				of Death	(Check only	one)		
on: To	1 Yes 2 No 27. Manner of eath Natural 5 Pending	28a. Pate	Inpatient 2 of Injury oth, Day Year)	ER/Outpatier 28b. Time o Injury		4 ∐ Nu ≀at		ne 5 🗆 Res 28d. Describe		Other (Spec	ify)
Certification:	2 \ \text{Accident} \ 3 \ \text{Suicide} \ 4 \ \text{Homicide} \ \text{Homicide} \ \text{investigation} \ \text{determine} \ determ	ot be 28e, Place	e of Injury - At h ing, etc. (Speci	ome, farm, sti	M 1 1 1	Yes 2 □ I	-		(Street and own, State)		ral Route Number,
edicai C	29a. Certifier (Check only one) 12 Certifying 2 Medical E	xaminer: On the b	e best of my kno casis of examina nner stated.	owledge, deat ation and/or in	n occurred at the tim vestigation, in my op	ne, date and pinion, dea	d place, a	and due to the	e cause(s) o, date and	and manner as place, and due	stated. to the cause(s)
Me	29b. Signature and title of certifier	for we			29c. License	number	18	2-	29d. Date	signed (Month	Day, Year)
	30. Name and address of person w	•	•		,		, .			2// C	D 20785
ate	Demetrios J. 31. Date filed (Month, Day, Year)	Catever	ni, M. Registrar's Signa	D. 30	01 Hospi	rtal	Dri	ve, C	пеле	тту, м	20105

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State of Maryl		artment of H <i>rtificate of L</i>				
			Registrar 1. Decedent's Name (First, Middle, Last)		inioato or E	Jean	2. Date of De.	ath 200	5 23. Time of Dath
ı	Physici /Medio		Ernest Lee Shifflett, Jr.				June		005 3:55 a M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	
		5 .	460 Broadwater Road		Arno			Anne	Arundel
	Funeral		45714 0005	yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	7, Year 1923	Birthplace (State or Foreign Country)
	Director		217-18-6725				Sep. 1	7, 1923	VA
	yland		10a. State 10b. County 10c	c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar	ctor	MD Anne Arundel		A	rnold			1 ☐ Yes 2 🔀 No
	h with th	ai Director	10e. Street and Number 460 Broadwater Road		10f. Zip Code	1012		10g. Citizen of Wh	at Country? USA
036	be filed within 72 hours after death with the Maryland that Hygiene. od other than "neturel", or Items 23a or 28e-1 show event, the Michael Examinst roual be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 No It Yes, Give Year or Dates:	TATATE	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
21215-0036	72 ho 'netur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa	durina most of won	sing	16b. Kind of Busin	ness/Industry
121	within lene. than "	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired, Truck Dri)	9	ጥተ	ansportation
	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last)				e (First, Middle	Maiden Sumame)	
Maryland	should be ad Mental marked o matic eve	To B	Ernest Lee Shifflett, Sr.				A. Lawso		
lar	2 sho and h Is ma	ľ	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a				ate, Zip Code)
S O	fealth fealth om 27 sher tr	1	Shirley Shifflett/Wife 20a. Method of Disposition 20	46 0b. Place of Dispo	0 Broadwa		44		012
nor	ages ant of H it: If ite y or of		1 XBurial 2 Commation 3 DRemoval from State	_cemetery, crei	matory or other place en Cemete		² 27, 2005	20c. Location - Ci	rnie, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic ev once.	1	21. Signature of Fun ral Service Licensee	22	2. Name and Addres	s of Facility			
8	88 = 88		ems EN aslone	4	95 Gov. R	itchie H	vy, Seve	erna Park	
П			23a a J. Fer the disease, or completations that caused the size k, or heart failure. List only one cause on each line.	dest . Do not ent	ter the mode of dying	g, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Prrysician /Medical		disease or cond tion resulting in death) Due to (or as a con	Joce	mded	inga	nche	n	
B	Examiner	1		Bena	renue (andie	myor	quu	
	ם ב	iner	Seour nitially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	nsequence of):			1		
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a con	nsequence of):					
8760,	icate be executed physician and s the burial-transit	aiE	Due to (of as a con	isequence or).					
687	ificate g phys as the	edicai	d.						
.O. Box	ne death certific the attending p thed for use as i	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of prediction in the past 12 months? 1 □ Live birth 2 □ II 4 □ Pregnant at time 9 □ Unknown	Fetal death 3[Ectopic pregnancy Other (specify)		1	23d. Date of Month	,
<u>α</u>	res that the de signed by the a be detached to	y Ph	Part II. Dther significant conditions contributing to death but no	t resulting in the u	inderlying cause giv	hi Part I	7 23e. Did to	obacco use contribi	ute to the cause of death?
S	res sign	D	Ibruey !	Jepen	m.1 -		7		
2	an and	(d)		- 11 -	Jan -	- ww	101	res 2□No 3	Probably 4 Unknown
score	aw require ts been sig 2 should b	piete	Home	J'T	Doulla	rlian	24a. Was	an 24b. We	re autopsy findings available
Records,	The larate has	Complete	- Affan	al F	Balla	dian	24a. Was autop perfo	an 24b. We prio dea	
		Be Completed	25. Was case referred to medical examiner?	al F	Dalla	lon 26. Place of Dea	24a. Was autop perfo 1 □ Yes	an 24b. We prio dea	re autopsy findings available or to completion of cause of th?
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			1.01	partment of Health and Men	tal Hygiene
	Discorte:		Decedent's Name (First, Middle, Last)		Date of Death Month Day Year 3. Time of Death
	Physici /Medi		Rita Marie Stahlman	1 _	une 24, 2005 11:45 A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Larkin-Chase Nursing Home	Bowie	Prince Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 220–58–7073 1 M 2 🕮 75 Yrs.	/) If Under 1 Year If Under 24 Hrs. 8. D Months Days Hours Min.	Date of Birth Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	Dec	2.13, 1929 Washington, DC
	and		10a. State 10b. County 10c. City, Town or	ocation	10d. Inside City Limits
	the Marylan 28a-f show	ō	MD Prince Georges Bowie		1X Yes 2 □ No
	28a	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	3e or	Ö	12800 10th Street	20720	USA
	ms 2	Jere	11 Marital Status 12, Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Specify of Yes, specify Cuban, Mexican, Puerto Ricar	
9	or Ite	Œ	1 Never Married 2 Married 1 Yes 2 No		
03	rel',	d by	3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	Specify: White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Hems 23e or 28e-f show that the Medical Exertiret must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
121	within ne.	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		-
2	filed with Hygiene. kther than	ပိ	12 Hom	emaker	Own Home
anc	ntal H	Be			st, Middle, Maiden Sumame)
Ž	2 should be filed within and Mental Hygiene. Is marked other than eumetic event, It's Me	2	Robert E. Robson 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Alice Qui	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depcriment of Heatih and Mental Hygiene. Importents if item 27 is marked other than "neturel", or items 23e or 28a-f show any injury or other treumetic event, if a Medical Exertiret must be notified at DECs.			00 10th Street Bowie,	
	1 and Health iem 27		20a Method of Disposition 20b. Place of Dis	position (Name of Date	20c. Location - City or Town, State
Baltimore,	Pages nent of H int: If its		cemetery, ci	ashington V	
⋣	permit. Pag Department Importent: I any Injury o	- 1	' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	22 Name and Address of Earling D. 1	
Ba	permit. Deports Imports any inj	0	fact	16000 Annapolis Road	
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. End Stage (chronic obstruction	Ve Sulmonous Distors The
Ш	Examiner		Due to (or as a consequence of):	enal Vasculan I	2100
		er	Sequentially list conditions, if any, leading to immediate b. Sequentially list conditions, Due to (or as a consequence of):	enal vascular L	JIstare 115,
	cate be executed oblysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Anteny Dister	~ \
Ć,	n and ial-tra	Exa	resulting in death) Last Due to (or as a consequence of):	10.00	19
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68	ifficate g phys as the	edi			
ŏ	The law requires that the death certificate be executed tie has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3		23d. Date of delivery
m	ne deat the atte	icia	1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	Month Day Year
P.0	that the ded by the detached	hys	9 ☐ Unknown		
S,	res tha igned be del	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ord	w require been si should I		Dianetes Melli	us	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
Vital Records,	ne law re has be ge 2 sho	Completed		2	24a. Was an autopsy findings available prior to completion of cause of
Ä	The page	E		3	autopsy prior to completion of cause of death? □ Yes 2 No 1 □ Yes 2 No
ita	icien: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Death (Che	
f V	S 5	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ont 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)
n of			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 1 Injury		Describe how injury occurred
Sio	ittendii death. ctor: A / the fu	atic	2 Accident investigation	M 1 Yes 2 No	
Division	ter d irect irect	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Le	ocation (Street and Number or Rural Route Number, City or Town, State)
	urs al		indiana in the second		
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier Certifying Physician: To the best of my knowledge, dea (Check only one) The basis of examination and/or and manner stated.	th occurred at the time, date and place, and do nvestigation, in my opinion, death occurred at	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	, 29c. License number	29d. Date signed (Month, Day, Year)
	⊢ s ⊢ ŏ		Pakexhandly M	D 20108	6/27/05
•			30. Name and address of person who completed cause of death (Item 23a) (Type	Print	0, ., 0
			Rakesh Arora, M.D. 14300 Gallant	· ·	20715
	Sta	te	31. Date filed (Month, Day, Year) 32. Pigistrar's Signature	DOWIE, FID	20713
	Registr		31. Date filed (Month, Day, Year) JUN 2 7 2005 32. Figistrar's Signature	book	

CPM 05-04473 Robert Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ert	Smith	71	1 - State Amend Item 1& Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylar Unpend Item 2	nd / Depa 23a, pt	artmen Titical	t of H e 877	ealth a		ntal Hyg 8-3-05 Re	h	005	23139 5: Time of Death
	Physici /Medio		Robert Leon Smit	ch Jr.						July	02,	2005	13:39 M
	Examir		4a. Facility Name (If not institution, give s 3298 Riva Road	treet and number)				Location o	of Death			ounty of Death nne Aru	ndel
	Funeral Director		213 32 3131 11	M 2 F	last birthday) 68 Yrs.	If Under Months	1 Year Days	If Under: Hours	Min. Se	Date of Birth (Month, Day Pt TO) ^{Yea} ()9:	9. Birthp 36 Mar	lace (State or Foreign lify) yland
1	Maryland a-f show fied at	itor 1	Usual Residence of Decedent 10a. State 10b. County Anne Art		ty, Town or Lo	cation						1	0d. Inside City Limits
	or 28s	Funeral Director	10e. Street and Number			10f. Zip			•	10	0g. Citizer	n of What Cour	ntry?
	leath v	eral	3298 Riva Road	2. Was Decedent Ever in U	J.S. 13.		2114 lent of Hi		gin? (Specify	Yes or No-	14	Race - Americ	SA an Indian
900	172 hours after death with the Maryland "naturel", or Items 23a or 28a-1 show Idical Examinational De crollined at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No		f Yes, spec		Specify:	gin? (Specify i, Puerto Rica	an, etc.)		Black, White,	
21215-0036	d within jiene. r then "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 8th			dent's Usua kind of wor DO NOT us Labor	rk done d se retired,	tion uring most	t of working	W			oyster&
nd	ld be filed ental Hygia ked other ic event,	Be C	17. Father's Name (First, Middle, Last)		3			18. Mothe	r's Name (Fi	rst, Middle, M			
Maryland	should be nd Mental marked o	P	Robert L, 19a. Informant's Name/Relationship (Type		105 Maille		/C44-			a Har		0 7	
	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		Eva L. Smith (Wi									own, State, Zip	
Baltimore,	ges 1 and 2 t of Health if Item 27 or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	20b. I	Place of Dispo cemetery, crer	sition (Nan natory or o	ne of ther place)	Date	Gales	20c. Local	tion - City or To	20765 wn, State
tim	Pa nen ant: ury		4 ☐ Donation 5 ☐ Other (Specify)	Cei	ryland metery				/8/05	C	rowr	nsvill	e, Md.
Bal	permit. Pa Departmer Important eny injury once.		21. Signature of Funeral Service License Larry H. Ree	a M00883	Tv	Name and R	a Addres Lees Lest	e & St.	sons Anna	Mortu	ary	P.A. 214	0.1
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or bomplis shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the deale cause on each line. Hypertensive Due to (or as a consection)	e ather	er the mode	e of dying	, such as	cardiac or re	spiratory arre	est,		Approximate Interval Between Onset and Death
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	uires that signed b lid be deta	þ	Part II. Dther significant conditions con Stomach cancer	inbuting to death but not res	sulting in the ur	nderlying ca	ause give	n in Part I.			acco use		e cause of death?
Vital Records,	The ate h page	Completed								24a. Was an autopsy perform	/	prior to cor death?	psy findings available inpletion of cause of 2 No
Vit	Physician: this certific ral director.	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	ospital:	ER/Outpatien	t 3 DO	A Othe	-		5 ☐ Resider	**	Other (Specify	SCENE
ion of	ding h. After fune		27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury Work		28d.	Describe hov			, 5011,11
Division	in the s	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of fnjury - At h building, etc. (Specia	ome, farm, str	eet, factory	, office			Location (Str. City or Town,		umber or Rura	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dii completely filled in	Medical	29a. Certifier 1 Certifying Phys (Check only one) Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, and h occurred a	due to the car t the time, da	use(s) and te and pla	d manner as st ace, and due to	ated. the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier	1 14		290	License	number CME		1		igned (Month, L	
			30. Name and address of person who con	mpleted cause of death (Iter	n 23a) (Type,	Print)	Dom	2 C+	100t T	0-1-2-		M 1	1 01007
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Regular's Signal	ature	111	reil	ı olr	eel I	oal tline	ore,	marytar	na 21201

DHMH 17 Rev 1/2001

		•	1 - For State Registrar	State of M	-	-	rtment of He tificate of D		-	ene g. No.2 A A E				
			Decedent's Name (First, Middle, La	st)					th 2 Those of DAAm					
	Physici		Herman	,	Stephen		Snoots		Month June	Day Year 28 2005	4:00 P M			
	/Medio Examin		4a. Facility Name (If not institution, give	e street and number)	ССРПСП		4b. City, Town, or		ounc	4c. County of Dea				
	LAGIIII	Ci	12506 Sunshine I	Orive			Cu	mberland		Allega	nv			
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Yrs. 7. Age (In yrs. last birthday) 1 M 1 M 2 F 5 Months 1 Mon								thplace (State or Foreign ountry)			
1	Director										Maryland			
	p .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d Incide City Limite			
	anyla shov	_			Toc. City, Town C	JI LOC	ation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	he M	Director	MD Alleg	gany			Cumberla	1 46						
	with t	ā		ъ.			10f. Zip Code	04.500	10	g. Citizen of What C	ountry ?			
	eath	erai	12506 Sunshin	12. Was Decedent	Ever in II S	13 V	/as Decedent of His	21502	ecify Ves or No-	USA 14. Race - Ame	erican Indian			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funerai	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 X Yes 2 1 If Yes, Give	No 1967-		Vas Decedent of His Yes, specify Cubar ☐ Yes 2 ☐ No	Specify:	Rican, etc.)	Black, Whi				
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altimore, Maryland 2	filed Hygi other		17. Father's Name (First, Middle, Last)		1101	-	18. Mother's Name	e (First, Middle, M					
	ld be ental ked c	To Be	Herman	Albert	Sr	noot	ts	Audrey	Adelin	ne	Webber			
	shound Mind Mind Mind Mind Mind Mind Mind Mi	-	19a. Informant's Name/Relationship	Type, Print)	19b. M	/ailin	g Address (Street a	nd Number or Rura	al Route Number,	City or Town, State,	Zip Code)			
	nd 2 alth a 27 ls		Linda L. Snoots / wif	e	125	506	Sunshine D	rive, Cumbe	erland, Man	ryland 2150	md 21502			
	s 1 a of Hez Item othe		20a. Method of Disposition		20b. Place of D	ispos	sition (Name of atory or other place	,	Date 2	Oc. Location - City or	Town, State			
	Page nent c int; If		1 🌠 Burial 2 □ Cremation 3 E 1 4 □ Donation 5 □ Other (Speci					. !	/2005 F	Flintstone	Maruland			
alti	mit. partm porta y inju		21. Signature Full eral Service Licensee MD Vet. Cem. @ Rocky Gap 07/01/2005 Flintstone, Maryland 22. Name and Address of Facility Adams Family Funeral Home, P.A.											
m	9 2 E 2 3		Kahut (allam			404 Decatu	r Street, (Cumberland	, Maryland :	21502			
Т			st,	Approximate Interval Between										
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):											
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Box (IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of de	livery			
m	death e atte d for	Physician/M	in the past 12 months?	4☐Pregnant at	2 ☐ Fetal death t time of death	Ectopic pregnancy Other (specify)			Month					
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_	spital		29a. Certifier 1X Certifying P	nysician: To the best	of my knowledge, o	death	occurred at the time	date and place	and due to the car	use(s) and manner as	stated			
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exa	miner: On the basis o and manner st	f examination and/o	or inv	estigation, in my opi	nion, death occurr	ed at the time, da	te and place, and due	to the cause(s)			
	To th withir To th	Me	29b. Signature and title of certifier	11.4. A			29c. License	number	29	d. Date signed (Mont	h. Day, Year)			
1	/IVA		> Homa Scale	e MD			D4634	.6		June 29,	2005			
	nas		30. Name and address of person who Huma Shakil,				onni) mberland, M	aryland 2	1502					
	Sta Registr		31. Date filed (Month, Day, Year) JUN 3 0 20	•	ar's Signature		,							
	negisti	GI	3011 3 0 20	- Jacob	- 7									

			For State Registrar	State of Ma	aryland		artment of rtificate o			ental Hyg	giene Reg. N&	05	23141		
	Physici /Medic	al	Decedent's Name (First, Middle, La MERCY M. SOLO Solution of the solution of the	MON			4h City Tayya			2. Date of Dea Month June	Day	Year 2005	3. Time of Death 10:50 P		
	Examin	er	Shady Grove Nurs				4b. City, Town		of Death		4c. County	gome	rv		
	Funeral Director		5. Social Security Number 6. S 215.06.2441		e (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Birti (Month, Day Dec . 28	h y, Year)		place (State or Foreign ntry)		
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits		
	Mary t-f sho	tor	Maryland Montgo	mery	Ga	ither	sburg						1₺Yes 2□No		
	ith the	Funeral Director	10e. Street and Number				10f. Zip Code	9			10g. Citizen of What Country?				
21215-0036	s 23a	eral	19523 Laguna Dri	ive 12. Was Decedent	From in 11 C	140.1	2087		:-:-0.40		U.S.A				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show array injusperyother traumatic event, the Medical Examinant intuit to indiffed at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		'	Was Decedent o If Yes, specify Ci 1 ☐ Yes 2🖾 N	uban, Mexicai	n, Puerto f	city Yes or No- Rican, etc.)	Bla	ck, White, y: Asi			
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	ould b Menta	ToB	Pi Jesudason					Mar		Jesudas					
	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (James S. Devaira				ng Address (Stre								
	s 1 and the Healt		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of	1		ate	20c. Location		nd 20879 own, State		
E C	Page Inft: H		1 ABurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special			-	natory or other p Heaven (,	06/24	/2005	Silver	Spri	ng, MD		
Baltimore,	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	Pasant		H 1	Name and Add INES-RIN 1800 Nev	dress of Facili NALDI I V Hamps	^{ty} FUNER shire	AL HOME Ave, S	INC.	Sprin	g, MD 20904		
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused one cause on each li aDementi	10.	Do not ent	er the mode of d	lying, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death 2 Years		
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Division of Vital Records, P.	uires that t signed by ild be deta		Chronic Ponol For Lune								23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown				
000	law requir as been si 2 should	Completed	Hypertension							24a. Was an 24b. Were autopsy find			ppsy findings available		
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o	Phys this al di): To	1 ☐ Yes 2 🖾 No 27. Manner of Death	28a. Date of Inju	ry 2	8b. Time of				me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred					
ion	ath. r: After ne funer	atlor	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 2 ☐ Accident investigation 4 1 ☐ Yes 2 ☐ No												
ivis		Certification:	3 Suicide 6 Could not be determined	eet, factory, offic	at, factory, office 28f. Location (Street and City or Town, State)					d Number or Rural Route Number,					
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	To the within To the Corrup	×	29b. Signature and title of certifier				29c. Lice	nse number		29d. Date signe	d (Month,	Day, Year)			
	2/		Day					28656		June 28, 2005					
	V		30. Name and address of person who Ravi Passi, M.D.					Suite #	208-	Rockyf	lle. Ma	rvlai	nd		
	Sta	te	31. Date filed (Month, Day, Year)	20 -0	ada Oias at			, <u>u</u>		HOURVI	, 11a	_ ,			
	Registr	ar	JUN 29 2	005 See	し は	RO	W								

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Registrar

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			For State Registrar			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Death				e n	05	2311.3		
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year										3. Time of Death					
	/Medic	al	Harriet K Schifter						Tour	Location of	of Dooth	June	2	-	2005 ty of Death	11:30P M		
	Examin	er	4a. Facility Name (If not institution, give street and number) Arden Courts							pring					gomer	37		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)							If Under		8. Date of I			-	place (State or Foreign		
	Director	or 072-09-4389 1							Days	Tiodis	IVIAI.	08/14/	1902	+		~York		
	land ow		10a. State 10b. Co			10c. C	ity, Town or Lo	cation							1	0d. Inside City Limits		
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	or 28	Dire	10e. Street and Number											Citizen of What Country?				
	s 23a	rall	10600 Pine D	ale I		dent Ever in 1	10 12 1	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						ted States 14. Race - American Indian,				
' O	r Rem	Fune	11. Marital Status 1 ☐ Never Married 2 ☐	Married	12. Was Decedent Ever in U.S. 13. \ Armed Forces? 1 \(\text{Yes} \) 2\(\text{X} \) No							Rican, etc.)				etc.		
))	ours a	d by	3 X Widowed 4 ☐ Divo	rced	If Yes, Give 1 Year or Dates:		1 ☐ Yes 2 🛣 No Specify:					Specify: W.			LTe			
5 -(filed within 72 hours after death with the Maryland Hygiene. ither than "natural", or Items 23a or 28a-f show int, Ite Medical Exerting Items Le truffiled at	letec	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k						lent's Usual Occupation kind of work done during most of working OO NOT use retired) 16b.						Kind of Business/Industry			
7	iene. r than	ошо	Elementary/Secondary (0-	12)	College (1-	4or 5+)				″ Assist				tion Hea		stitute		
bu	e filec al Hyg I other vent,	3e C	17. Father's Name (First, Mic	ddle, Last)			-1	18. Mother's Name (First, Middle,						Maiden Surname)				
<u>ya</u>	ould b Ment warked	101	Asher Kleinman Harriet New									an						
Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Exertent meater profilled at once.		19a. Informant's Name/Reia Kenneth Schi					•				Silve						
<u>6</u>	Heal Heal		20a. Method of Disposition				Place of Dispo	sition (Na	me of			Date	-, <u>-</u>		- City or To			
E	Page: nent o ant: If Iry or		1 ØBurial 2 ☐ Crema 1 Ø Donation 5 ☐ Other			tate	Leba:	-	otrier piac		06/28	3/2005	Ad	elph	i, MD			
Baltimore,	epartn epartn nporte ny inju		21. Signature of Funeral Ser	vice Lip en	300	000	22 H i	Name a	nd Addres	ss of Facilit	y			-				
	005€0		22a Part Enter the disease	A Town	diagtions that or	used the dea						Ave S		r Sp	ring,	MD 20904 Approximate		
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final												Interval Between Onset and Death				
	Pnysician /Medical		disease or condition resulting in death) Advanced Alzheimers Disease Due to (or as a consequence of):															
	Examiner		Sequentially list conditions		b. Eczematosis Dermatitis of the Chest Wall Dua to (or as a consequence of):													
	pe tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1														
	xecut	Examiner	that initiated events resulting in death) Last	1	c. Anemia Due to (or as a consequence of):													
760,	ate be executed hystcian and the burial-transtt	cal			, d.													
89	ortifica ing ph	Medi	IF FEMALE:															
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy										23d. Date of delivery Month Day Year					
o	the de y the a	yslc	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown					specify)										
Δ.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	by Physician/Med	Part II. Other significant con	nditions co	ontributing to de	ath but not re	sulting in the u	nderlying	cause give	en in Part I.		23e. Di	d tobacco	use co	ntribute to th	ne cause of death?		
Records,	w require been sig should b											1 (Yes	2 No	3 Prob	ably 4 XUnknown		
ec	a law r has be	Completed										24a. W	topsy		prior to co	psy findings available mpletion of cause of		
alF	ician: The lav certificate has rector, page 2 :											1 TYes	rformed?			death? 1 ☐ Yes 2 ☐ No		
Vital	S =	o Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ※ No	idical	Hospital:	npatient 2	ER/Outpatien	nt 3 🗆 🗅	OA Oth			n <i>(Check on)</i> me 5□Re		6 □0	ther (Specif	v)		
n of	ding Phy h. After thi funeral o	Ju: T	27. Manner of Death 1 X Natural 5 □ Pe	ending	28a. Date o		28b. Time of	-	28c. Injun	y at		28d. Describ				,,		
Sio	tendii Jeath. tor: A the fu	catle	2 Accident in	vestigation				М	711	Yes 2 🔲	_	00/ 1				1 See to March 2		
Division	l or Attendatter death Director:	Certification;	4 Homicide	etermined	28e. Place buildir	of Injury - At r ig, etc. (Speci	nome, farm, str ify)	eet, facto	ry, office				own, Sta		nber or Hura	al Route Number,		
_	To the Hospitel or At within 24 hours after of To the Funerel Direc completely filled in by		29a. Certifier 1X Cer	tifying Ph	ysician: To the	best of my kn	owledge, deatl	h occurre	d at the tin	ne, date an	d place,	and due to the	ne cause	(s) and r	nanner as s	tated.		
	the Ho in 24 the Fu	ledical	one)		iner: On the ba and mann	er stated.	ation and/or in				th occurr	ed at the tim						
		Σ	29b. Signature and title of ce	extition of	·V	ohra	2 MI		c. License						ned (Month,	Day, Year)		
	10		30. Name and address of pe	rson who	completed cause	of death (Ita	m 23a) (Type		D202	74			06/	27/	2005			
			Kirti Vohra,						a, M	D 208	17							
	Sta		31. Date filed (Month, Day, 1		105 32 A	egistrar's Sign	the for	selle)										
	Registi	ar	JUIY A	1 9 C	IUJ CA	TURE !	-	4.5										

Chaltu Shubo 05-4615 AKG

	an	1. Decedent's Name (First, Middle, Las. Chaltu Shubo	")					2. Date of De Month	ath Day	Year	9: Time of Dea		
/Media	cal				1			July			5:30 A		
Examir	er	4a. Facility Name (If not institution, give Washington Advent:		-01		wn, or Locatio				ty of Death			
uneral		5. Social Security Number 6. Se		·a.L e (In yrs. last birthday	If Under 1		ler 24 Hrs.	8. Date of Birt	th.	t gome	ery nplace (State or For		
irector		220-61-1752	⊐м 2 X О F	25 Yrs.	Months [ays Hour	s Min.	Jan. 1,	1980	Col	intry) niopia		
>		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L									
r 28e-f ehow	5			,,							10d. fnside City Li 1 ☐ Yes 2X		
28e-f	Director	Maryland Mon 10e. Street and Number	tgomery	Tak	oma Par			10a Citizan o	Og. Citizen of What Country?				
23a or	Ö	7667 Maple Aven	ue, #1104		101. 2100	20912			Ethiopia				
ma 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Deceden	t of Hispanic	Origin? (Sp	ecify Yes or No Rican, etc.)		ace - Amer	ican Indian,		
il, or its	by Fur	1 Never Married 2 A Married 3 Widowed 4 Divorced	1 Yes X			Rican, etc.)		Black, White, etc. Specify: Black					
natura edical E	ted	15. Decedent's Ed	dent's Usual (Occupation			16b. Kind of	Business/li	ndustry				
	pje	(Specify only highest grad Efementary/Secondary (0-12)	DO NOT use	done during m retired)	ost of work	ring							
other than	Completed	12	lespers	son			Retail						
event.	Be	17. Father's Name (First, Middle, Last) Edasa Shubo						e (First, Middle,	Maiden Suma	ame)			
nark	ို	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru						Rabo					
important: If item 27 ie marked oth eny injury or other treumatic even pace.		Tsegaye Gelgelo/									ID 20912		
	1	20a. Method of Disposition		20b, Place of Disp	osition (Name	of	1	Date	20c. Location				
= 0		1 Burial 2 ☐ Cremation 3 🗗 4 ☐ Donation 5 ☐ Other (Specify		Arsi Neg	matory or other			y 11, 05	Arsi Ne	egele	, Ethiop		
inju		21. Signature of Funeral Service Licens		H ²	2. Name and	deress of Fa							
EEE		J. Keen Skiles		5	00 Univ	versity	Blvd	l, W, Si	lver S	pring	, MD 209		
3		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	fications that caused	the death. Do not en	ter the mode o	f dying, such	as cardiac	or respiratory ai	rest,		Approximate Interval Betwee		
sician		fmmediate Cause (Final disease or condition	_	Arrhythmi	а						Onset and Dear		
edical		resulting in death)	α	a consequence of):									
miner		Sequentially list conditions.	b	a consequence of):									
##	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
sicien and burial-transit	Examiner	that initiated events resulting in death) Last											
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ج و ا			d.										
attending p	Physician/Me	fF FEMALE: 23b. Was decedent pregnant				23d. D	ate of deliv	/ery					
e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	⊒Ectopic pregi ⊒ Other <i>(speci</i>					lonth	Day Year				
<u> </u>	hys	9 Unknown											
by t	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did t							tobacco use contribute to the cause of death				
gned se del	ted							101	res 2□No	3 ☐ Pro	bably 4 Unkn		
6 8	0							24a. Was	sv	prior to co	opsy findings avai		
been sign should be	힏								rmed? 2 ☐ No	death?	2□ No		
ate has been sign page 2 should be	Compl						ace of Deat	h (Check only o	ne)				
ate has been sign page 2 should be	Be Completed	25. Was case referred to medical examiner?	Hospitali			Other: 4		me 5 Resid			rfy)		
this certificate has been signi af director, page 2 should be	To Be	examiner? 1☆ Yes 2 No	Hospital:					how injury occurred					
ifier this certificate has been signi uneral director, page 2 should be	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 ☐ fnpatie 28a. Date of fnju (Month, Day		of 28c.	Injury at Work?				t and Number or Rural Route Number,			
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				For State Registrar	State	of Maryla	•	artment o			lental Hy	giene Rog. N	005	2211.5
		Physici		Decedent's Name (First, Middle, La	ast)	aine S	actt.				2. Date of De Month		ACO:	3. Time of Death
		/Medio Examir		4a. Facility Name (If not institution, gir			2000	4b. City, Tov	vn, or Loca	tion of Death	June	4c. (County of De	
		Funeral		5. Social Security Number 6.	Sex 1 □ M 2X F	7. Age (In yr.	s. last birthday)	If Under 1 Y Months D	ear If U	nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da Sept. 2	th y, Year)	9. B	rthplace (State or Foreign country)
		Director		Usual Residence of Decedent		69	Yrs.				Sept. 2	24,19	35 M	aryland
		Marylar -f show fied at	tor	10a. State 10b. County Maryland Cec	il	10c. C	City, Town or Lo		Depos	sit				10d. Inside City Limits 1 ☐ Yes 2% No
		with the	Director	10e. Street and Number				10f. Zip Co	de			10g. Citiz	en of What C	•
		leath v	Funerai	1103 Bainbridge		edent Ever in	U.S. 13.	Was Decedent	21904		acity Yes or No	h 1		S.A.
	980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed F	orces? 2⊠No ive		If Yes, specify 1 ☐ Yes 2 ☑		xican, Puerto	ecify Yes or No Rican, etc.)	i	Black, Wh	
	15-0	in 72 ho n *natur Vedical	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual O kind of work d DO NOT use re	one durina	most of work	ing		d of Busines County	s/Industry Activity Center
	212	ed with giene. er tha	Com	Elementary/Secondary (0-12)	Four :	Years		Teach	er		_	Elkt	on, I	Maryland
	Baltimore, Maryland 21215-0036	uld be file Aental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Las. Alexande		iams			18. N		e <i>(First, Middle,</i> rgarett			
	/lar	2 sho and h ls ma		19a. Informant's Name/Relationship	(Type, Print)		1				Al Route Numb	,		
	ē,	Health Health tem 27 other t		Carla Robertson 20a. Method of Disposition		20b.	Place of Dispo	sition (Name o	of	-	t. 3-B,			MD 21001 r Town, State
	mo	Pages nent of ant: If i		1 🖾 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Speci			cemetery, cret okesbur	matory or other y Cemet		07/0	5/05	Port	Depos	it, Maryland
	Balt	permit. Departr Importe any inju		21. Signature of Funeral Service Lice	nsoe TAN	. NA QC	< L	2.Name and A ee A. F erryvil	atter	son &	Son Fur			P.A.
*	8760,70	cate be executed /Medical Examiner bhysician and the purial-transit the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b. Due to	(or as a conse	equence of):	7	y ac					Interval Between Onset and Death Mon ISS
	Vital Records, P.O. Box 6	To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live	tcome of pregr birth 2 ☐ Fe nant at time of lown	tal death 3	Ectopic pregn Other (specif				23	d. Date of de Month	blivery Day Year
5	ds, P	uires that signed b	þ	Part II. Other significant conditions	contributing to c	leath but not re	sulting in the u	nderlying caus	e given in P	Part I.		obacco us		o the cause of death?
Sholdy	Il Recor	ysician: The law requir is certificate has been si director, page 2 should	Completed								24a. Was autor perfo	an osy rmed? 2 X No	24b. Were a prior to death?	utopsy findings available completion of cause of
	Vita	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2[☐ ER/Outpatier	a ⊒□ DO4		12	(Check only o		T011 (0-	
F	Division of	ding Phys h. After this funeral di	tion; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o	28c.	Injury at Work?		me 5 ☐ Resid 28d. Describe !			ecity)
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		To the Hospitel within 24 hours a To the Funeral completely filled	Medicai (29a. Certifier (Check only one) 1 Certifying Pl	mi <i>n</i> er: On the b	e best of my kr pasis of examination	nowledge, deat nation and/or in	n occurred at the vestigation, in r	ne time, dat my opinio <i>n</i> ,	e and place, death occurr	and due to the ed at the time,	cause(s) a date and p	nd manner a lace, and du	s stated. e to the cause(s)
		To the To the comp	Ž	29b. Signature and title of certifier	- 4 - 4	M	٨		ense numi			29d. Date	signed (Mon	th, Day, Year)
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		Y			11 hauri	M	noc R	evoluti	ons S	+ Ma	Wre De	Cr	ace	MD21078
		Sta Registr		31. Date filed (Month, Day, Year))5 Real	Registrar's Sig	ature	W		1				

			For State Registrar	State of M	laryland /		artmeni rtificate			and Me		giene Reg. NG) ()) [22116
	Physici		1. Decedent's Name (First, Middle, I		Stephens	5					Date of Dea Month June 2	ath Day	Year	12:30 P ^M
	/Medic Examir		4a. Facility Name (If not institution, g		_		4b. City,	Town, or	Location o		omie z		unty of Dea	
			Calvert Memori	al Hospita	a1		Pri	ince	Fred	erick			Cal	vert
	Funeral				ige (In yrs. last b		If Under Months		If Under a		Date of Birti	h v. Year)		thplace (State or Foreign
	Director		219-38-9933	1□M 2\\ F	99	Yrs.		Dayo	riodis		arch 2	8, 190	06	Germany
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits
	Aaryl f sho	ō		lvert										1 Tyes 2 No
	28a-	Director	10e. Street and Number	TAGE C	Hun	CTHE	town	Code				10g. Citizen	of What Co	
	With Ba or		830 Carson Roa	d			1011.2.1		200					outiny (
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural, or items 23a or 28a-f show avant, the Medical Examinar must be routified at	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13. \	Was Deced		639 Spanic Orig	gin? (Speci	fy Yes or No- can, etc.)	US 14. I		erican Indian,
ယ	or Ite		1 Never Married 2 Married			1				, Puèrto Ri	can, etc.)		Black, Whit	
<u>Ö</u>	ral', c	b	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1 ☐ Yes 2	K No	Specify:			Spe	ecify: V	White
5-0	72 hc natu	Completed	15. Decedent's (Specify only highest of	Education	16	a. Dece	dent's Usua kind of wor	Occupa	tion	of working	,	16b. Kind o	l Business	/Industry
21	within ene. than "	ldu	Elementary/Secondary (0-12)	College (1-4o	5+)	life.	DO NOT us	e retired)		or working				
2	filed w Hygier othar ti		13 Falls 1 Nova (First 16:14% 1	- 41			Home						Home)
ano		Be	17. Father's Name (First, Middle, La: George	St)	Ott	_					First, Middle,	Maiden Sun	name)	**
Maryland 21215-0036	s 1 and 2 should be f Health and Mental itam 27 is markad othar traumatic av	-T	19a. Informant's Name/Relationship	(Type Print)			a Addross	(Street a		ther:	LITE Route Numbe	· City or To	04-4-	Hess
<u>≅</u>	d2 sold 2		Richard West (s				Carso							, ,
စ်	of Health itam 27		20a. Method of Disposition	OII-III-Iaw)	20b, Place	of Dispo	sition /Nam	e of		$June^{0at}$	ngtown		20639 on - City or	Town, State
lo I			1 🔀 Burial 2 ☐ Cremation 3 '4 ☐ Donation _5 ☐ Other (Spec		Pi !	-	natory or ot ark C			2009				
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B	permit. Departr Importa any inji		Gary	_			wings			, 012: 357 I	iJuoo C	nern M	iaryta Homo	nd Blvd Calvert, PA
	Physician /Medical Examiner		23a, Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each	ed the death. Do		er the mode	of dying						Approximate Interval Between Onset and Death
,8760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate ease. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	325	s a consequence	3 K	rtem	j d	isea	SP				
P.O. Box 6	that the death certific ed by the attending p detached for use as t	Physiclan/Me	IF FEMALE: 23b. Was decedent pregrant in the past 12 morths? 1 □ Ves 2 ≥ No 9 □ Unknown		e of pregnancy 2 □ Fetal deat at time of death		Ectopic pre Other (spe					23d.	Date of del Month	ivery Day Year
	res that Igned b be deta	by	Part II. Other significant conditions Dementia						. 1	itis	23e. Did to	1/		othe cause of death?
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Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical	2	6				26. Place	of Death	Check on or		1 1 1 1 0 3	20110
<u>_</u>	dis y	10	examiner? 1 Yes 2 No	Hospital: 1 Inpat	ient 2 ER/C	utpatien	t 3 🗆 DO	Othe	r. 4 □ Nur	sing Home	5 Resid	ence 6 🗆	Other (Spe	cify)
Division of	ing After une	Certification;	27. Manne of Death 1 Natural 5 Pending 2 Accident investigati	1	ury 28b. ay Year)	Time of Injury	M 28	Bc. Injury Work		286	d. Describe h			
Divi			3 Suicide 6 Could not determine	d 286. Place of it building, e	njury - At home, l etc. (Specify)						City or Tow	n, State)		ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	one)	Physician: To the bes aminer: On the basis and manners	or examination a	ge, death nd/or inv	estigation,	in my opi	nion, deat	d place, and h occurred	at the time, o	late and plac	ce, and due	to the cause(s)
	To To	Σ	29b. Signature and title of certifier				29c.	License	number		2	29d. Date sig	gned (Monti	h, Day, Year)
7			AMMDW	HOV			1	00	6013	20		0/4	4/05	
_	2		30. Name and address of person wh	o completed cause of	death (Item 23a)	(Type,	Print)				, ,	1.	/	
	X Sta	to.	31. Date liled (Month, Day, Year)	32. Regis	tra/s Signature	PITA	1 Kd	· P	zinc	6 1-12	edruc	15 , 1	DE	0678
	Registr		30. Name and address of person wh A. Waei Ha 31. Date lifed (Month, Day, Year)	2 9 2005	Boon	K	Loc	W						

			-	State of Marylar			lealth and Me	•	•	
			For State Registrar			rtificate of			2005	2311.7
	Dhuaisi		1. Decedent's Name (First, Middle, Last),				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		I Kenz Toda					10 2	8 200	5 1230 M
	Examin	er	4a. Facility Name (If not institution, give	- 0 - 1		4b. City, Town, o	r Location of Death		4c. County of Deat	h . <i>:</i> *
	Funeral		5. Social Security Number 6. Se		last bilthday	If Under 1 Year	If Under 24 Hrs.	B. Date of Birth	9. Birt	hplace (State or Foreign untry)
	Director		220-01-9997 15	JM 2/2 102	Yrs.	Months Days	Hours Min.	(Month, Day, Yea		ryland
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c, C	ty, Town or L	ocation			•	10d. Inside City Limits
	Maryli f sho	jo	Maryland Wicomic		lisbury					12€ Yes 2 □ No
	r 28e	Directo	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Co	untry?
	death with the Maryland rms 23a or 28e-f show		300 Lemmon Hill	L		2180°	1		USA	
	er de a	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
336	ars aft	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: W	hite
2-0	be filed within 72 hours after death with the Marylar Hygiene. At Hygiene. And other than "natural; or Items 23a or 28e-f show other than "natural; or Items 23a or 28e-f show event, the Medical Examinat must be indiffed at		15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup	pation during most of working	16b.	Kind of Business/	Industry
2	vithin ne. han *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			d)		3	
2	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)	2	nome	emaker	18. Mother's Name	(First, Middle, Maid	domestic	
a	should be nd Mental marked o matic eve	To Be	Clarence Parker				Verta P	arsons		
Maryland 21215-0036	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (T)				and Number or Rural			
	s 1 and 3 f Health Item 27 other tr		Dr. Nevins W. Too				ottom Ct.,	-		
altimore,	e = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	nemoval mom state		osition (Name of matory or other place			Location - City or	
			'4 ☐ Donation 5 ☐ Other (Specify,			Cemetery 2. Name and Addre	7/1/0		alisbury,	
B	permit. Departr Imports any inj.		1 The How	200	E	Holloway 1 501 Snow 1	Funeral Ho Hill Rd.,	me Profes Salisbury	sional A 7. MD 218	ssociation 04
			23a. Part 1 Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea						Approximate Interval Between
Z	Priysician		Immediate Cause (Final disease or condition resulting in death)	a. Asc	VD					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
	4	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):					
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursaass or injury that initiated events	c.						<u> </u>
,092	ite be executed lysiclen and ne burial-transit		resulting in death) Last	Due to (or as a conse	quence of):					
	a × a	edicai		d						
Box	eath certific attending pl	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					23d. Date of del	ivery
о. В	Attending Physician: The law requires that the death certifica robath. coath. sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No	1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown		□Ectopic pregnancy □ Other (specify) _	у		Month	Day Year
<u>Р</u>	that the de led by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions co		sulting in the	inderlying cause on	on in Part I	23e Did tohaco	o use contribute to	the cause of death?
ds,	uires tha signed Id be det	d by	Tarris established	annealing to addit but not no	Summing 111 1110 1	shoonying odeso gre	ron in a with.	1 ☐ Yes		obably 4 donknown
S	w requir s been s should	ojete						24a. Was an	24b. Were au	itopsy findings available
Vital Records,	The lav	Completed						autopsy performed	? death?	completion of cause of
/ita	ysician: The is certificate he director, page	Be	25. Was case referred to medical examiner?			T.D.	26. Place of Death	(Check only one)		w.h.
of	Physic this or	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatie		ner: 4 ☐ Nursing Hom	e 5 Residence		city) Hiving
on	nding Phy th. : After this e funeral c	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo			,,,	80
Division	l or Attence after death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, si	treet, factory, office	2	Bf. Location (Street City or Town, St		ural Route Number,
	urs aft rral DI									
	To the Hospitel or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my kn siner: On the basis of examin and manner stated.	iowledge, dea lation and/or i	th occurred at the ti nvestigation, in my o	me, date and place, a opinion, death occurre	nd due to the cause d at the time, date	a(s) and manner as and place, and due	s stated. e to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier			29c. Licens	se number	29d.	Date signed (Mont	h, Day, Year)
V	3		Nafyw	/		ð	47094		6/30/0	5
	0		30. Name and address of person who co		em 23a) (Type	, Print)	and 16	(A . C B)	va. M	2,804
	Sta	ato		32. F gistrar's Sign	nature	3.010151	UN SF.	17425	- 129	40/
	Registi		31. Date filed (Month, Day, Year)	005 Mour	JE 1	porte				

			1 - For State of Maryland /		artment of H		nd Me		iene		
	0.	Marc	Decedent's Name (First, Middle, Last)				2	. Date of Death	201	5	8. Time of Depth
	Physicia /Medid		Ondina Thomas					June		year 005	5:00 p M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or				4c. County of		
			2925 Marlow Farm Terrace 5. Social Security Number 6. Sex 7. Age (In yrs. last to	vieth day)	Silver	Sprin		Date of Righ	Montgo		<u>/</u>
П	Funeral Director			Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, 12/15/1	Year) 933	Cuba	ace (State or Foreign try)
	D		Usual Residence of Decedent						1		
	shov	J.	10a. State 10b. County 10c. City, To							10	Od. Inside City Limits 1 Yes 2 No
	the N	Director	Maryland Montgomery Silve	r Sp	10f. Zip Code			10	ng. Citizen of Wh	nat Coun	
	3a or	i Di	2925 Marlow Farm Terrace		20904	+			U.S.A.		.,,.
	ems 2	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hi	spanic Orig	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	14. Race	- America	
36	filed within 72 hours after death with the Maryland Hygiene. other then "natural", or Items 23e or 28e-f show ant, the Modical Extractional be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No If Yes, Give		1⊠Yes 2□No	Specify:	Cuba	,	Specify:		ite
Maryland 21215-003	2 hour	ed b	15. Decedent's Education 16	a. Dece	dent's Usual Occupa	ation	-		16b. Kind of Bus		
215	thin 72 9. an "na Madi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done a DO NOT use retired,	luring most)	of working	7			,
7	ygien ygien rar th	Con	12	Food	Service						ol System
and	ntat H ad oth	Be	17. Father's Name (First, Middle, Last) Armando Cabrera					First, Middle, N nandez	faiden Surname,)	
<u> </u>	should id Me mark imatic	ဥ		- b. Mailir	ng Address (Street a				City or Town S	tate. Zin	Code)
S	alth ar 27 Is				Marlow Fa					. ,	,
ore,	of He fitam		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State	of Dispo	sition (Name of matory or other place	9)	Dat	te 2	20c. Location - C	ity or Tov	wn, State
Baltimore,	Pag ment tant: I		`4 □ Donation 5 □ Other (Specify) Ft.		oln Cemet				Brentwoo		
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylann Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, ite McGle Ext. "line matter notified at once.		21. Signature of Funeral Service Licensee Myelin T. Mobert								Home, Inc., MD 20904
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ent	er the mode of dying	g, such as o	cardiac or I	respiratory arre	est,		Approximate Interval Between Onset and Death
	Pnysician /Medical-	H	Immediate Cause (Final disease or condition resulting in death) a		Arrest					- 74	Onset and Death
	Examiner		Due to (or as a consequence Extensive Me		atic Ader	no Car	ccino	ma			
	19	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				o z mo.			- 61	
	cuted nd transit	Examiner	that initiated events c. <u>Carcinoma or</u>	Co]	on						
8760,	cate be executed physician and the burial-transit	H Ex	resulting in death) Last Due to (or as a consequence	e of):							
687	ficate physi s the t	edical	d								
Box	that the death certif ed by the attending detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea	ac	35-4				23d. Date	of deliver	ry
	e deat he attr	sicla	in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death	_	Ectopic pregnancy Other (specify)	-			Mont	n I	Day Year
P.0	hat the id by t detach	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting	in the u	adorhina cauco avec	o in Part I		23a Did tob	acco use contrib	ute to th	e cause of death?
Records,	es pe	d by	The first significant contained contained in the death but not resulting	in the u	riderlying cadse give	miniranti.					ably 4 Unknown
COL	w requir	Completed						24a. Was ar	24b. W	ere autor	osy findings available
Re	The lav te has age 2	omp						autopsy perform	ned? de	ath?	osy findings available apletion of cause of 2 No
Vital		BeC	25. Was case referred to medical examiner?			26. Place	of Death (Check only one	24-11-	2163	292140
of V		ဥ	1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 ☐ ER/C		the same of the sa	4 🗀 1901			nce 6 □Other)
ou c	ding Pt h. After th funeral	llon:	1 Matural 5 Pending (Month, Day Year)	. Time o Injury	Work	rat ⟨? Yes 2		d. Describe ho	w injury occurred	1	
Division	Attending r death. actor: After by the fune	ifical	3 Suicide 6 Could not be determined 28e. Place of Injury - At home,	farm, st			-	f. Location (Str	eet and Number	or Rural	Route Number,
ā	tal or is afte al Dira	Certification:	4 - Horridae Duilding, etc. (Specify)					City or Town	,		
	To the Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, deat and/or in	h occurred at the tim vestigation, in my op	e, date and pinion, deat	d place, an	d due to the ca at the time, da	use(s) and mani ite and place, an	ner as sta id due to	ated. the cause(s)
	To the vithing To the comp	Me	29b. Signature and Wash confiden		29c. License	number	1	29	d. Date signed	(Month, E	Day, Year)
)	3		· un son south (11)		MD	518	//		6/28/200)5	
			30. Name and address of person who impleted duse of death (Item 23a								
	Sta	ate	Dr. Nelson Trujillo 2021 K 31. Date filed (Month, Day, Year) 32-Registrar's Signature JUN 2 9 2005	St;	Washingto	n DC	20006	·			
	Regist		JUN 29 2005 Hour &	A STATE OF THE PARTY OF THE PAR	wer.						

			For	State of Maryla				nd Mental Hy	•	pie.
			1 - For Stata Registrar		Ce	rtificate of	Death		Rag. No.2	15 2311.9
	Physicia		1. Decedent's Name (First, Middle, Last) Richard Martin Th	omas. St.				2. Date of Dea Month	Day	Yeer 1 O/ D M
	/Medio Examin		4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of	June 2	8 2005 4c. County	1:04 P M
			62 Baycircle Drive			Earlevi		t blee to a second	Cecil	
	Funeral Director		5. Social Security Number 6. Sex 197 - 48 - 0863	M OFF	rs. last birthday) 48 Yrs.	Months Days	If Under 24 Hours	Min. B. Date of Birt (Month, Da June 11	y, Year) 1957	Birthplace (State or Foreign Country) PA
	put		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits
	Maryla	ō	MD Cecil		Earlevil					1 ☐ Yes 2 🛣 No
	th the or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?
	s 23e		62 Bay Circle	0.144	. 11.0	21919		-0.40	USA	A ion Indian
CO.	after de or Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No 				n? (Specify Yes or No- Puerto Rican, etc.)		e - American Indian, k, White, etc.
003	ural', o	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No				white
<u> </u>	in 72 h	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of ad)	of working	16b. Kind of Bu	siness/Industry
212	ad with rgiene. er thai	Com	Elementary/Secondary (0-12)	College (1-4 <i>o</i> r 5+)		ineer			Aviat	ion
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or Items 23s or 28s-f show imatic event, Ite Medical Examiner must be notilled at	Be	17. Father's Name (First, Middle, Last)	l. c				s Name (First, Middle,	Maiden Sumam	Θ)
3	K P E E	င္	William Raymond T 19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Address (Stree		h Beck or Rural Route Numbe	er, City or Town,	State, Zip Code)
	s 1 and 2 soft Health ar Item 27 is other trau		Eleanor Thomas/wi					leville, M	D 21919)
Baltimore,	Pages 1 and the nent of He nent of He nent or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State		osition (Name of matory or other pla	0 /	-05-2005		City or Town, State
Ħ	permit. Pages Department of Important: If It any injury or o		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi	R	I Foar	id Funera 2. Name and Addr	L Home	P.A.	Rising S	Sun, Maryland
Ba	Deport Impo			1	3	318 Georg	je Stre	et, Chesap	runera eake Cir	P.A. ty, MD 21915
		-	23a. art1. Enter the disease, or compli- shock, or heart allure. List only on	cations that caused the de cause on each line.	eath. Do not ent	ter the mode of dy	ing, such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Couse (Final disease or condition resulting in death)	/ AS	phyx	ud				Onset and Death
	Examiner			Due to (or as a cons	sequence of):					
0	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence of):					
1	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					
760,	b ys	calE								
x 68	ertifica ling ph e as th	Med	IF FEMALE:							
Вох	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnance Other (specify)	у		23d. Dat Mo	e of delivery hth Day Year
P.O.	that the de ted by the a detached t	hysi	9 🗆 Unknown	9□ Unknown						
ds,	w requires that been signed to should be det		Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	<i>i</i>	ibute to the cause of death? 3 Probably 4 Unknown
Records,	w requ	Completed						24a. Was		Vere autopsy findings available
Re	The law cate has page 2:	omo						—– autop	rmed?	rior to completion of cause of leath? ☑ Yes 2☐ No
/ita		Be	25. Was case referred to medical examiner?	itali				of Death (Check only o	ne)	
of	Physic r this carrel dire	i: To	1 Yes 2 No 27. Manner of Death	ospital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatier	IL SEL DOA			dence 6 GOthe	er (Specify) scene
lon	Attending Physician: r death. ector: After this certific by the funeral director,	atior	1 ☐ Natural 5 ☐ Pending investigation	Month, Day Year	12:34	f 28c. Inju	ork? Yes 200 No			angled
Division of Vital	or Attencater death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	reet, factory, office		28f. Location (S City or Tox	Street and Numbern, State) 6 2	er or Rural Route Number, Bayc I v Clc D
	Hospital 24 hours a Funeral Detely filled i	al Ce	29a. Certifier 1 ☐ Certifying Phys	ician: To the best of my	LLUCL knowledge, deat		ime, date and	place, and due to the	Pause(s) and ma	nner as stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only one) Medical Examir	er: On the basis of exam and manner stated.	ination and/or in	vestigation, in my	opinion, death	occurred at the time,	date and place, a	and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	91000	nd	29c. Licen OCM	se number E			(Month, Day, Year)
	V		30. Name and address of person who co			Print)			June 29	
	U			100			nn Stre	eet Baltin	nore, Ma	ryland 21201
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Si	gnature de	de .				
		и.	707 1 7003	- July	-					

			1 - For State Registrar		ate of M	aryland .		artment tificate			and M		Reg. No.	005	5 2	315	50
	Physici /Medic	al	1. Decedent's Name (First, Middle John 4. Seeilih, Name (If and institution)	Willia		Wils	son	45 05 7		Sr.	(5-4)	2. Date of De. Month	- 1 O	-20	ar OS	3. Time of 0	
	Examin	er	4a. Facility Name (If not institution 32 Virginia Aver					Cum	berl				All	egany			
	Funeral Director		5. Social Security Number 212-38-5557	6. Sex 1 X M 2		ge (In yrs. last	Yrs.	If Under 1 Months	Days Days	If Under Hours	Min.	8. Date of Bin Jul 15,	th 1940	9.	MD Birthplace	e (State or	Foreign
Maryland	f show	.or	Usual Residence of Decedent 10a. State MD Alleg	jany		10c. City, T		erlanc	<u> </u>						10d.	Inside City	
with the	a or 28a	Direc	10e. Street and Number 32 Virginia Aver	nue				10f. Zip (21502	<u> </u>		10g. Citiz	en of What	Country	?	,
1215-0036 within 22 bours after death with the Marvland	Department of Health and Mential Hygiene. Important: or items 23a or 28a-1 show important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Wa	as Decedent med Forces? Tyes 2 Tyes, Give har or Dates:	?	i	Was Decede f Yes, specif 1 ☐ Yes 2	ent of Hi			cify Yes or No Rican, etc.)		4. Race - A	Vhite, etc.		
Maryland 21215-0036	iene. r than "natur ine Medical	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	t grade com	oleted) ollege (1-4or	5+1	6a. Deced (Give life. I	dent's Usual kind of work DO NOT use	Occupa done d retired	ation during most)	t of workir	1		d of Busine			
land 2	Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Robert Lee W									(First, Middle,		,			
Mary od 2 show	alth and M 27 is man r traumat		19a. Informant's Name/Relations John Wilson Jr.	nip (Type, Pr	int) SON		19b. Mailir 1109	Brad	Street a	k Roa	er or Rura	LaVal	er, City or e	Town, Stat	тө, <i>Zip C</i> o	215 215	02
MO	nent of Health nt: If Item 27 ry or other tr		20a. Method of Disposition 1 Description 2 Cremation 4 Donation 5 Other (S		al from State	cemi	etery crer	sition (Name natory or oth emeter	her olaci	θ)		ate 7/13/2005		ation - City			ľΩ
Balti	Depertm Importa any inju		21. Signature of Funeral Service	Licensee	AN	U.	22					me, P.A. Cumber	land. I	MD 218	502		
	nysician /Medical		23a. Perf 1. Inter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	se on each li	ine. DNAR	1 1								Ap Int	oproximate terval Betw nset and Do	eath
E	xaminer	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Erner Uniderlying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or as	a consequent a consequent a consequen	ice of):										•
P.O. Box 68760, A	ned by the attending phy detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	10	Live birth	of pregnancy 2 ☐ Fetal de It time of death	ath 3	Ectopic pre Other (spe					23	3d. Date of Month	delivery Da	y Ye	ear
چ ہے	signed by		Part II. Other significant condition	ens contributi	ing to death b	out not resulting	ng in the u	nderlying ca	use give	en in Part I.		23e. Did to		e contribut		cause of de	
Œ g	age	Completed										24a. Was autop perfo		prior death	to comple	r findings aveletion of cal	vailable use of
of Vital	is certifical director, p	o Be (25. Was case referred to medica examiner?	Hospita	al: 1 □ Inpati	ont 2050	(Output of	2 7 700	Othe	25		(Check only o		T011 (6	2		
Division of	ith. r: After this e funeral di	1-	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	9	a. Date of Inju (Month, Da	urv 28	Outpatier Bb. Time of Injury		ic. Injury Work	/ at	2	ne 5 AResid 8d. Describe h		Other (S	<i>ърес</i> ту)		٠
Divisi	s after death	Certification:	3 Suicide 6 Could 4 Homicide determ		e. Place of In building, e	jury - At home tc. <i>(Specily)</i>	e, farm, str	eet, factory,	office		2	28f. Location (3 City or Tox	Street and vn, State)	Number or	r Rural Ro	oute Numb	er,
T Jestinash av	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai (29a. Certifier 1 Certifyir (Check only one)	Examiner: C	To the best on the basis on and manner st	of examination	idge, death and/or in	n occurred a vestigation,	t the tim	ne, date an pinion, dea	d place, a	and due to the	cause(s) a date and p	and manner place, and	r as state due to the	ed. e cause(s)	
T of	withii To the	×	29b. Signature and title of certifie	·	1 8	1		29c.	License	number			29d. Date	signed (M	onth, Day	v, Year)	
•	, h	S	30. Name and address of person	who complet	d cause of	death (Item 23	Ba) (Type	Print))-	148	65		10	レイ	11;	120	105
	10	10	Robustiano Ba		M.D.	ı	Mem.	Hosp	Ме	d Bldg	g Cui	mberlar	nd ME	2150	02	5	4
	Sta Regista		31. Date filed (Month, Day, Year)		2. Regist	rar's Signature	for	W									

LARRY OLIVER WHITAKER

			Please	State of Manua					•	
			1 - For Stete Registrar	State of Maryla		rtificate of				00/80
			Decedent's Name (First, Middle, Last	st)		inoute of		Reg. N. 2. Date of Death	:005	3. Time of Death
	Physici /Medio		Ruth Ann Win	dsor				Tune a	7 2005	5 1708 M
	Examin		4a. Facility Name (If not institution, give		Lali		or Location of Death	4 magain	County of Death	4
	Funeral		5. Social Security Number 6. So	General 1 8x 7. Age (In y)	rs. last birthday)	If Under 1 Year	Mbridge If Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign
	Director		213-42-2233 Usual Residence of Decedent	□ M 2 F 6	Vre	Months Days	Hours Min.	(Month, Day, Year March 2,		**
	show	5	10a, State 10b, County	nester 10c.	City, Town or Lo		New Marke	ı+		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	ith the N or 28a-1	Funeral Director	10e. Street and Number			10f. Zip Code			itizen of What Cou	
	s 23a	rail	5942 Heritage R				21631		USA	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other treumetic event, It a Machical Examiner interior by notified at ORGE.	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		was Decedent of F f Yes, specify Cub	Hispanic Origin? (Specian, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: W	
2-0-1	in 72 hou	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	g 16b. i	Kind of Business/li	ndustry
717	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		homemak	er		own home	
and	12 should be filed will and Mental Hygien is marked other three reumetic event, Ite	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Maide	n Sumame)	
Z Z	ould to	2	James Marvin		-			ta E. Pri		
Mar	d 2 sh sh and 7 is m treum		19a. Informant's Name/Relationship (7			•	and Number or Rural	01 500	CS 100	
ā	tem 2		Robert Windsor 20a. Method of Disposition	husband 20b	5942 D. Place of Dispo	Heritag sition (Name of matory or other pla	e Road, Ea	st New Mai te 20c. L	cket, MD ocation - City or T	21631 Fown, State
paltillinor	Pages ent of nt: If I		1 Surial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	nemovariioni State			್) al Park 6/	30/05 C:	ambride,	MD
	permit. Departm Departm Importa any inju		21. Signature of Funeral Service Licen	. (. Name and Addre		omas Funei		
מ	89 5 8		John John John	mer		700 Locu	st St., Ca			
	nysician		23a. Part1 Finer the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that caused the decone cause on each line.			ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to for so a com						
	Examiner	_	Sequentially list conditions,	b. Arteriosc	levohe	Hear	1- dise	afe		
	red	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. Arterio sc Due to (or as a cons c. Cere hio U	requence on s	r Ac	Cident			
<u>.</u>	execunation and ial-tra	Exar	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
,007	ite be iysicla ne bur	cai		d						
9	artifica ing ph e as th	Med	IF FEMALE:							
ממ	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 F	etal death 3□	Ectopic pregnancy	у		23d. Date of deliv	very Day Year
5	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	1 Tes 2 No	4□Pregnant at time o 9□Unknown	rdeath 5L	Other (specify) _				
_	s that ned b e deta	by Ph	Part II. Other significant conditions co				ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
cords,	aquire en sig ould b	ed t	Chronic	Reval	Fail	ure		1 □ Yes	No 3□ Pro	bably 4 Unknown
ງ ນ	law re as be 2 sho	Completed						24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
ב =	: The cate h page	Con						performed? 1 ☐ Yes 2 ☐ No	death?	≯€Ro
VII.	certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death			
5 1	r this	To :	1 Yes 2 70	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of		1er: 4 ☐ Nursing Home	e 5 Residence		fy)
5	nding ith. r: Afte e fune	atior	1 Accident 5 Pending investigation		Injury	Wor	rk? Yes 2 □ No			
DIVISION	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funnel Director. After this certificate has been si completely filled in by the funeral director, page 2 should	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · Al building, etc. (Spe	t home, farm, streetly)	eet, factory, office	28	of. Location (Street and City or Town, State		al Route Number,
:	e Hospit 24 hours e Funere letely fille	edical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exam	ysician: To the best of my k liner: On the basis of exami and manner stated.	nowledge, death ination and/or inv	n occurred at the tir vestigation, in my o	me, date and place, an opinion, death occurred	d due to the cause(s I at the time, date an) and manner as s d place, and due t	stated. to the cause(s)
1	To the Comp	Me	29b. Signature and title of certifier	» d A		29c. Licens			ite signed (Month,	**
			1 Jack	MD		D4	7924	6.	27.0.	5
			30. Name and address of person who o			Print) LA STRI	EET CAM	RRIPLE	MD 2	1613
	Sta Registr		31. Date filed (Month, Day, Year).	32. Redistrar's Sig	mature	Andre .				
	41091311	11111	Company of the A		1 115	Carlotte Carlotte				

			For State Registrar	State of M	aryland / Dep	artment of			- 0	^ ^ ~	00150
			Decedent's Name (First, Middle, La	st)		Timoato o	Dodin		Reg. No	5002	Z Jime of Death
	Physici	an						Mont	h Da		G. Time of Death
	/Medi		Pearl Burton 4a. Facility Name (If not institution, give	Willey	1	4b. City, Town	or Location o	Jui		2 200 c. County of De	
	Examir	ner			,			DI Death	-		
			Mallard Bay Car 5. Social Security Number 6.5		ge (In yrs. last birthday		ridge ar I If Under	24 Hrs. 8. Date	of Birth	Doro	chester
	Funeral Director			□M 2 2 F	Vec	Months Day		Min. (Mon.	th, Day, Year		Birthplace (State or Foreign Country)
			Usual Residence of Decedent		90 ***			May	25, 19	915 19	Maryland
1	Maryland -f show		10a. State 10b, County		10c. City, Town or L	ocation.					10d. Inside City Limits
5	Man	ţ	MD Dorche	ster		Cambr.	anhi				1 X Yes 2 □ No
2	1 the	Director	10e. Street and Number			10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10g. C	itizen of What	Country?
0	3a o		520 Glenburn A	Tropus			21613	2		1102	
2	death with the ms 23a or 28e I must be noti	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S. 13	Was Decedent of		3 igin? (Specify Yes n, Puerto Rican, et	or No-	USA 14. Race - Ar	mencan Indian,
(0	r Ite	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces	, No	,			c.)	Black, W	hite, etc.
8	hours after turel', or Ite al Examine	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 N	lo Specify:			Specify: W	hite
21215-0036	72 ho	Completed	15. Decedent's E		16a. Dec	edent's Usual Occ	upation	4 - 6	16b. F	Kind of Busines	ss/Industry
2	within 7 ene. then *r	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	e kind of work don DO NOT use reti		i or working			
21	d wit	no.	8	00090 (1		secreta	ry		1	food pr	ocessor
Þ	oth oth	Be C	17. Father's Name (First, Middle, Last)			18. Mothe	er's Name (First, N	fiddle, Maidei	n Sumame)	
<u>a</u>	Aenta Aenta rked rice	To	John Insley				Mai	rtha Will	ev		
Maryland	shot and A		19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ing Address (Stre		er or Rural Route I		or Town, State	, Zip Code)
Σ	alth a		Kirk Bloodsworth	grands	on 513	6 Airevs	Road.	Cambrid	e Mi	21613	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatih and Mental Hygiene. Importent: If tiem 27 is marked other then "naturel", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Exercises must be rediffied at any injury or other treumatic event, the Medical Exercises must be rediffied at ances.		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other p		Date			or Town, State
£	Page ent o ht: If		1 ABurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special		Dorchest			rk 6/25/	'05 C=	mbri da	o MD
≣	permit. Par Departmen Importent: any injury once.		21. Signature of Funeral Service Lice			2. Name and Add				al Hom	
Ba	Departiment Department		BirR					, Cambrid			
			23a. Part1. Enter the disease, or com	plications that cause							Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each	ine.						Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	LaY	ge left	Cerei	MO NOS	culer	Acci	dens.	-
	Examiner			Due to (or a:	s t consequenc t of):						
		<u>_</u>	Sequentially list conditions,	b	a consequence of,						
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	220 10 (01 41	a consequence on.						
_	and I-trar	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
8760,	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	a E									
87	phys the	dicai		d							
9 x	death certific attending pl	Physician/Me	IF FEMALE:	23c. If yes, outcome	of programmy					- 11	
Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnar				23d. Date of d Month	delivery Day Year
	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregnant a 9□ Unknown	t time of death 5	Other (specify)					,
P.O.	res that the de signed by the a be detached f	Ph	Part II. Other significant conditions	contributing to death i	but not requiting in the	and ask in a second	nume in Dont I	220	Did tehnoon	una aantributa	to the cause of death?
S,	res ti	Completed by	Dene		out not resulting in the	andenying cadse (giveri ili ranti.	, 238.			
Records,	w require been si should b	ted			Fibrilla	1 -			1 Yes 2	.□N0 3□	Probably 4 Unknown
S	law as b	pie	Chronic	ATTICI	FIDITILA	200		24a.	Was an autopsy	24b. Were	autopsy findings available o completion of cause of ?
æ	The ate h page	Non						10,	performed?	death	? es ≱ZÎNo
ita	ian: rtifica	Be (25. Was case referred to medical				26. Place	of Death (Check			/ <
_	ysic is ce direc	To E	examiner? 1 □ Yes 2 No	Hospital: 1 Inpati	ent 2 ER/Outpatie	nt 3 DOA	Other: 4 Vu	irsing Home 5	Residence	6 ☐Other (Sp	pecify)
Division of Vital	g PF ter th neral		27. Manner of Death	28a. Date of Inj (Month, Da	ury 28b. Time	of 28c. in			cribe how inju		
0	ath. r: Af	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		.,,,		☐Yes 2☐I	No			
<u>×</u>	Atte	ific	3 Suicide 6 Could not b	286. Place of in	jury - At home, farm, stc. (Specify)	reet, factory, offic	е		tion (Street a		Rural Route Number,
Ö	s after	Certification:		ballaling, o	to. (Opeany)			Ony (s rown, otal	5)	
	hour hour mere y fille		29a. Certifier Certifying Pt	ysician: To the best	of my knowledge, dea	th occurred at the	time, date an	d place, and due to	the cause(s) and manner	as stated.
	ne Hd	edical	(Check only 2 Medical Examone)	and manner s	of examination and/or it tated.	rvestigation, in my	opinion, deal	th occurred at the	time, date an	d place, and d	ue to the cause(s)
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	×	29b. Signature and title of certifier	Closur		29c. Lice	nse number		29d. Da	te signed (Mo	nth, Day, Year)
			1 auni	filling Mil)	DI	1792	4	6	.23 .	25
		1	30. Name and address of person who	completed cause of	death (Item 23a) (Type		-	,	1		
			MONTAN THANG	7 -			CAMA	RIDGE	111)	2161	3
	Sta	ite	31. Date filed (Month, Day, Year)	1	r s Signature	Red	Pag.	J (J) (L)		- 10'	
	Registi		JUN				, D				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Yeer 11:10 AM **Physician** 22 June Aletha Jeanne Tydings Wheeler 2025 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Future Care Chesapeake Anne Arundel Arnold If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🗑 F 220-48-7958 31, 1910 Maryland Director Aug. Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location in then "natural", or items 23s or 28s-f show the Madical Examinational be notified at 1 X Yes 2 No Directo Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 108 Tolson Street 21401 United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: White δ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) th and Mental Hygiene.

7 is marked other then traumatic event, Its Market Elementary/Secondary (0-12) Administrative Services U.S. Government belil ed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy Vernon Tydings Elizabeth Howard Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a 145 Kurtz Mill Road Mohnton, Pennsylvania 19540 Linda W. Hess / Daughter other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or ā Hillcrest Memorial Cem. 6/27/2005 Annapolis, Maryland *4 □ Donation 5 □ Other (Specify)

21. Signature up Pervice cen e 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acide Myocardial Infarction /Medical Due to (or as a consequence of) Examiner disease arten Oronari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that inhiated events resulting in death) Last Due to (or as a consequ Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) ned by the a P.O. 9 Unknown 9 Unknown been signed t should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ ★ Q of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Ursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? ne Hospitel or Attending P n 24 hours after death. ne Funeral Director: After t Certification: After Division 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 å 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 22, 2005 D57531 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 860 Veterans wegi MD 21108 Mobil Millersville Day Year) UH 2 7 2005 32. Resistrar's Signature State Registrar

ORIGINAL

	1 - State Registrar				Ce	rtificate of	Death			Reg	, 18. []	105		231	5
	1. Decedent's Name (Fi	îrst, Middle, L	.ast)						2. Date of	Death	2	<u> </u>		3. Tim	e of De
an	F	Anna		M.		Wise		,	Month July	2,	Day	2005	ear	2:55	5 A
ai er	4a. Facility Name (If not	t institution, g	ive street and nu	ımber)		4b. City, Town, o	or Location	of Death				ounty of I	Death	200	<i>J</i> 11
	Memorial H	lospital				Cumber	land						A11	legany	7
	5. Social Security Numb		Sex	7. Age (In y	rs. last birthday	If Under 1 Year	If Under		8. Date of	Birth	()	9.		lace (Sta	
	206-07-1267		1 ☐ M 2 💢 F	97	Yrs.	Months Days	Hours	Min.	(Month, 08/13				-	nry) isylva	
	Usual Residence of Dec								00/13	7170			теш	15 y 1 V c	ша
	10a. State 10	b. County		10c.	City, Town or L	ocation							1	0d. Inside	1
Director	PA	Bed	lford		Hynd	man								1 🗆 Y	/es 2]
Le	10e. Street and Number	r				10f. Zip Code				100	g. Citizer	of Wha	at Coun	itry?	
2	4468 Hy	yndman F	Road				15545					USA	A.		
runerai	11. Marital Status		12. Was Dec	cedent Ever in	U.S. 13.	Was Decedent of H	Hispanic Or	rigin? (Spe	ecify Yes or	No-	14.			an Indian	١,
2	1 Never Married	2 Married		2- No	•				nican, etc.)			Black, \	wnite,	etc.	
ò	3 X Widowed 4 □	Divorced	Year or [Dates:		1 ☐ Yes 2 ☐ No	Specify:				Sp	ecify:	W	hite	
1	15.	Decedent's	Education grade completed,)	16a. Dece	dent's Usual Occup	oation	et of worki	ina	16	b. Kind	of Busin	ness/Ind	dustry	
Completed	Elementary/Secondar			(1-4or 5+)	life.	DO NOT use retire	d)	, or works	.,9						
5	unknown			•	Hot	ısekeeper	,				Hire	ed Do	mest	ic	
Bec	17. Father's Name (Firs	it, Middle, La	st)			-	18. Moth	er's Name	(First, Mide	dle, Ma				-	
To	John		Calvii	n	Mil	er		Emma			Wi1	lard			0ste
	19a. Informant's Name	/Relationship	(Type, Print)		19b. Mail	ng Address (Street	and Numb	er or Rura	al Route Nu	nber, C	City or To	own, Sta	ate, Zip		
	Shirley A.	Smith .	/ niece		446	8 Hyndman I	Road, I	Hyndma	n, Peni	nsvl	vania	15.	545		
	20a. Method of Disposit	tion		201	. Place of Disp	osition (Name of	1		Date	-				wn, State)
	1 X Burial 2 □ CI 4 □ Donation _ 5 □					matory or other place • Mem Park		07/06/	2005		Rod	ford	DΛ		
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	23a. Part1. Enter the d		mulications that	anna S	Do not on							Land	21.		mata
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	Immediate Cause (Fina	al													nd Dea
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DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month Pay, Year 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Legistrar's Signature

Christopher Willmann 05-4322 AKG

Ţ			1- State of Mar Registrar	-	artment of H <i>rtificate of I</i>			ene I. No. O		
	Physici /Medic		Decedent's Name (First, Middle, Last)	Willmann			2. Date of Death	20 26, 200	9-5 5 ^{ear}	27 mg оран 6 4:05 Р м
	Examir		4a. Facility Name (If not institution, give street and number) Montgomery General Hospital		4b. City, Town, or Olney	Location of Death		4c. County of		ry
	Funeral Director		213-23-1834 ¹⊠м 2□F	In yrs. last birthday) 21 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Oct. 13	(ear) 1983		ace (State or Foreign try) Yland
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Md. Montgomery	Oc. City, Town or Lo	ocation				10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23e or 28	al Director	10e. Street and Number 4368 Morningwood Drive		10f. Zip Code	20832	100	g. Citizen of W United		
936	d within 72 hours after death with the Maryland jene. Ir then "neturel", or items 23e or 28e-1 show The Medical Examinar rust be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Every Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	, White, e	
21215-0036	within 72 hou ene. then "neture the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give		turing most of worki	ng 16	5b. Kind of Bus		
land 2	ld be filed v ental Hygie ked other t ic event, III	o Be Co	12 1 17. Father's Name (First, Middle, Last) John Steven Willmann	Auto	o Body Pa	inter 18. Mother's Name Sloan	(First, Middle, Ma	Auto F aiden Surname Hillia)	r
, Maryland	les 1 and 2 should be filled of Health and Menial Hygis if Item 27 is marked other or other treumetic event, It	_	19a. Informant's Name/Relationship (Type, Print) Sloan Mary Spezia / Mother		12.	and Number or Rura gwood Dri				Code) 18 3 2
Baltimore,	Pages 1 annual of He end of He		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)		sition (Name of matory or other place itan Crem	θ)		Alexano		
Balt	permit. Pages Department of Importent: If is eny injury or once.		21. Signature of Funeral Service Licensee Murief H- Bard	22		s of Facility Barber ox 5038,			Id. 2	0882
	Physician	5000	23a. Part1. Enter the disease, or complications that caused it shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	e death. Do not ent	er the mode of dying	g, such as cardiac o	r respiratory arres	t,		Approximate Interval Between Onset and Death
0,	/Medical Examiner b physician and as the privial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):						
Box 68760,	ath certif	lan/Medical	d	Fetal death 3	Ectopic pregnancy			23d. Date		y Day Year
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ords,	requires sen sign rould be	eted by	Part II. Other significant conditions contributing to death but	not resulting in the di	ndenying cause give	erin Parti.	1 Tyes	-1		e cause of death?
Vital Records,	The la ate has page 2	Completed						nd? pri	or to com atb?	sy findings available ipletion of cause of
of	ding Physicien: 7 h. After this certifica funeral director, p	n: To Be	25. Was case referred to medical examiner? ★□ Yes 2 □ No Hospital: 1 □ Inpatient 27. Manner of Death 28a. Date of Injury.	28b. Time of		4 Li Nursing Hor	ne 5 Resident Resident Resident)
Division	or Atten ifter deat Director: in by the	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined (Month, Day Y	5 31.29	PM 101	res 2 No	MGTOVEYELE 281. Location (Stree City or Town,	et and Number	or Rural E 10	Collision Boute Number.
	he Hospitel in 24 hours a he Funerel I pletely filled	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of examiner: On the basis of examiner state	kamination and/or inv	n occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the cau ed at the time, date	se(s) and man and place, an	ner as sta id due to	ited. the cause(s)
)	To the To the Complet	W	29b. Signature and title of cedifier M. J.		29c. License OCI	ΜE		une 27,		
				(1),	Print)11 Penr	n Street	Baltimor	re, Mar	yland	d 21201
	Sta Registr	_	31. Date filed (Month, Day, Year) 32 Registrar's	s Signature	evile					

			For State	State of Mary		partment of He ertificate of D			_		
			Registrar 1. Decedent's Name (First, Middle, L	ast)		Crimeate of D	Catri	2. Date of Dea	ath	005	2. fune of Leath?
	Physici /Medic		BERNARD	DEAN	WAR	DEN		June 2	20 Day	2005	3:52A
	Examin	er	4a. Facility Name (If not institution, gi			4b. City, Town, or Lo	ocation of Death	a		ounty of Death	merv
	Funeral			Sex 7. Age (In	yrs. last birthda	ay) If Under 1 Year	_	_			place (State or Foreign
	Director		229-12-0332	1 2 5M 2□F 83	3 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Oct. 3]	19:	21 Vi	rginia
	yland Jow		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or	Location				1	0d. Inside City Limits
	se Mar Se-f sl	Director	MD Montg	omery	Sil	ver Spring	3				1 □ X es 2 □ No
	death with the Maryland ms 23e or 28e-f show f must be notified at		10e. Street and Number 531 Randolph	Road #332A		10f. Zip Code 2090	06		-	on of What Cour. $S.A.$	ntry?
	death	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 1	Was Decedent of Hisp If Yes, specify Cuban,		cify Yes or No	- 14	. Race - Americ	
920	be filed within 72 hours after death with the Marylan lat Hygiene. d other then "netural", or liems 23e or 28e-1 show event, it a Madical Examiner must be notilised at	ρ	1 ☐ Never Married 2 🔁 Married 3 ☐ Widowed 4 ☐ Divorced	12 Yes 2 □ No]	L943- L946	_ ~~	Specify:	rican, etc.)		Black, White, Specify: B	etc. lack
ζ O	72 ho	Completed	15. Decedent's I (Specify only highest g	Education rade completed)	16a. De	cedent's Usual Occupative kind of work done dure. DO NOT use retired)	on ring most of worki	ng	16b. Kind	d of Business/Inc	dustry
7	within iene. then '	Jup	Elementary/Secondary (0-12)	College (1-4or 5+)	4	echanic			Au	tomoti	ve
Maryland 21215-0036	e filed al Hygi I other vent, I	ø	17. Father's Name (First, Middle, Las			1.	8. Mother's Name			итате)	
<u> </u>	should be i and Mental i s marked or umatic eve	10	Elijah Ward					ie Dea			
<u>s</u>	nd 2 sh Ith and 27 Is n r treun	17	19a. Informant's Name/Relationship Carrie Ann Wa			ailing Address <i>(Street and</i>					7(1911h
ore,	es 1 ar of Hea litem		20a. Method of Disposition Salarial 2 Cremation 3	20		sposition (Name of crematory or other place)		ate	20c. Loca	ation - City or To	own, State
Baltimore,	tment tent:		`4 □ Donation 5 □ Other (Spec	ify) I		erans Cem	6/29			wnsvil	
ga	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked in you juy age ther treumatic extrem		21. Signature of Funeral Service Lice	5 MOUC	les	22. Name and Address 246 N Was	~ ~ ~				ome, P.A. D20850
			23a. Part1. Enter the Isease, or conshock, or heart failure. List only	nplications that caused the yone cause on each line.	death. Do ot	enter the mode of dying,	such as cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
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68/60,	icate be executed physician and s the buriat-transit	edical	•	Pneumo:	nia						<u> </u>
	eath certific attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr	egnancy				23	d. Date of delive	201
). Box	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 □ 4□Pregnant at time 9□Unknown		3 □Ectopic pregnancy 5 □ Other (specify)				Month	Day Year
л О	hat the de id by the de detached	Phys	9 ☐ Unknown Part II. Other significant conditions		t resulting in the	e underhing cause given	in Part I	23e Did to	phacco use	e contribute to th	ne cause of death?
Records,	The law requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	ted by							∕es 2 🔀		ably 4 Unknown
Seco	has be	Completed			-			24a. Was autop	sy	prior to cor	psy findings available mpletion of cause of
Vital F		e Cor	25. Was case referred to medical				10 Pl ()	1 ☐ Yes		death?	X No
	ıysicie iis cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Anpatient	2 ER/Outpa	Other	4 ☐ Nursing Hor			☐Other (Specif)	()
o no	ing Ph After th uneral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time Inju	ry Work?	t 2	28d. Describe h			
Division of	Attend death octor;	flcat	2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place of Injury -	At home, farm,		s 2 No	28f. Location (5	Street and	Number or Rura	l Route Number,
á	rs after el Dire ed in b	Certification:	4 Homicide determine	building, etc. (S)	pecify)	-		City or Tox	vn, State)		
	To the Hospitel or Attending Physicien: within 24 hours after death. Ja the Funerel Director: After this certific: completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying F (Check only 2 Medical Executions)	Physician: To the best of my aminer: On the basis of exa- and manner stated.	knowledge, de mination and/o	eath occurred at the time, r investigation, in my opin	, date and place, a nion, death occurre	and due to the e	cause(s) a date and p	nd manner as st lace, and due to	ated. the cause(s)
	withir comp	Me	29b. Signature and title of certifier	10000000		29c. License r				signed (Month,	*
	5		>-	> 14000011 10	(10-00:00	D592	284		Jι	ine 20,	, 2005
			J. S. Shamin	m, 1500 For	est G	len Rd Sil	lver Sp	ring,	MD 2	20906	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 9	2005 32. Pogistrar's S	Signature	post					

			1 _ State	state of Maryland /	-	artment of H			0000	22150
	Oharria		1. Decedent's Name (First, Middle, Last)	ght, Jr.	061	incate of t	Jeani	2. Date of Dea	ith	3. Time of Death
	Physici /Medi							June	28, 20°	05 8:30p ^M
	Examir	er	4a. Facility Name (If not institution, give stre			4b. City, Town, or		ath	4c. County of D	Death
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last i	birthday)	Elkton	If Under 24 H	rs. 8. Date of Birth	Cecil	Birthplace (State or Foreign
	Director		217-20-3703	2□ F 72	Yrs.	Months Days	Hours M	rs. 8. Date of Birth n. (Month, Day 0 3 / 1 4 /	1933 Ma	aryland
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	e Mar ta-f sh tiffed	ctor	MD Cecil	Elkt	on					¥∰¥es 2 □ No
	with th	Dire	10e. Street and Number			10f. Zip Code		I .	10g. Citizen of What	•
	ns 23	erai		Prive Was Decedent Ever in U.S.	13. V	21921	spanic Origin?	(Specify Yes or No-	United S	Menican Indian.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. After then "naturel", or items 23e or 28a-f show ant, the Medical Exemples must be notified at	Completed by Funeral Director		Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:	l II	Yes, specify Cubai	Specify:	erto Rican, etc.)	Black, W	hite, etc. Black
2-0	72 ho natur	eted	15. Decedent's Educati (Specify only highest grade co		a. Deced	lent's Usual Occupa kind of work done d OO NOT use retired,	ition uring most of w	orking	16b. Kind of Busine	ess/Industry
12	within ene. then	duic	Elementary/Secondary (0-12)	College (1-4or 5+) O H		00 NOT use retired, 7 Machin			Govern	ment
	il Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)		cuv	, maomin	18. Mother's N	ame (First, Middle.		110110
ylar	Menta	ToE	George E. Wright					Gibbs		
, Maryland	and 2 sh salth and n 27 Is m		19a. Informant's Name/Relationship (Туре, Iona Wright, Dau					Rural Route Number Or. Elkt		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Angles.		20a. Method of Disposition Darial 2 □ Cremation 3 □ Removed 4 □ Donation 5 □ Other (Specify)	oval from State Bohe	of Dispos Pery, crem M1a	sition (Name of natory or other place Manor	07,		20c. Location - City Chesape	or Town, State eake City, MI
Balt	permit. Departimport Import any inj		21. Signatur of Foneral Service General	anul	_	Name and Address				ay Avenue n, DE 19805
П			23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	ons that caused the death. Quase on each line.	not ente	er the mode of dying	, such as cardi	ac or respiratory arr	est,	Approximate Interval Between
Z	Priysician /Medical	Y j	Immediate Cause (Final disease or condition resulting in death)	Colon		ancle				Onset and Death
	Examiner			Due to (or as a consequence	e of):					/
_	υ .π	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):					
<	and I-trans	Examin	that initiated events c resulting in death) Last	Due to (or as a consequence	e of):					
8760,	ficate be executed physician and s the buriat-transit	dical E	d		2.,,					
9	ntificat ng ph) s as th	Medi	IF FEMALE:				-			
.O. Box	The law requires that the death certifi tte has been signed by the attending bage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1□Live birth 2□Fetal deat 4□Pregnant at time of death 9□Unknown		Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
<u>α</u>	signed by	by	Part II. Other significant conditions contrib	uting to death but not resulting	in the un	derlying cause give	n in Part I.	23e. Did tob		to the cause of death? Probably 4 _Unknown
Records,	w requires been s should	lete						24a. Was a		
Be	The lav	Completed						autops perforn	ng∧d? ∣ death	autopsy findings available to completion of cause of ? es 2 \sum No
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	20.1				eath (Check only on		
_	Physi this c	٩	1 ☐ Yes 2 No Hosp 27. Manner of Death 2	I Inpatient 2 ER/C	utpatient Time of	3☐ DOA Other	4 🗆 Nursing	Home 54 Reside	nce 6 Other (Sp	pecify)
0	nding Ph tth. :: After th	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	es 2 □No	200. (2004)00 110	w injury occurred	
Division of	Hospitel or Attenc 44 hours after death Funerel Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined 2	8e. Place of Injury - At home, in building, etc. (Specify)	arm, stre	et, factory, office	1 = 0 40 = 200	28f. Location (Sti City or Town		Rural Route Number,
	To the Hospitel or Attending Physicien: whithin 24 hours after deals as after deals To the Funerel Director: After this certific completely filled in by the funeral director.	edical C	Check only 2 Medical Exeminer:	on: To the best of my knowledge On the basis of examination a and manner stated.	je, death nd/or inve	occurred at the time estigation, in my opi	e, date and place nion, death occ	e, and due to the ca urred at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mo	nth, Day, Year)
			If farlos	MD		DI	53/	4:	Inla 1	2005
	5		H T /	eted cause of death (Item 23a)	(Type,	rint) H		11	all !	If the Elkton
	Sta	te	31. Date filed (Month, Day, Year)	32. Pegistrar's Signature	15/1	vorjo	12/1	unega	of earch	wayice My
	Registr		JUL - 1 2005	Brown &	4	and a				

		Decedent's Name (First, Middle, La			Jerinica	nt of Health and 05 tas te of Death	2. Date of D		2005	4315
ician			erson				Month	Day	Year	3. Time or Death
dical niner		4a. Facility Name (If not institution, given			4b. City	, Town, or Location of De	July	4c. C	2005 ounty of Death	1258
niner		Howard County Ge		tal		lumbia			oward	
al	5	5. Social Security Number 6. 5	Sex 7. Age ('In yrs. last birth	day) If Und	er 1 Year If Under 24 H				place (State or Fore
or		212-00-5541	1□ M 2以(F	52 Y	rs.	Days Hours III	Dec. 2	8 1952	2	MD
	-	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town	or Location				T	10d. Inside City Lim
į	5	Maryland Anne A	rundel			Pasadena				1 ☐ Yes 2 💢
Be Completed by Funeral Director	3	10e. Street and Number	- dildei		10f. Z	ip Code	· · · · · · · · · · · · · · · · · · ·	10g. Citize	n of What Cou	intry?
- C	2	1052 Kings Road				21122			USA	
Funeral	5	11. Marital Status	12. Was Decedent Event Forces?	er in U.S.	13. Was Dec If Yes, sp	edent of Hispanic Origin? ecrfy Cuban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0- 14	. Race - Amen Black, White	
by Fi		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give			2 X No Specify:			pecify: Wh	_
d be	2	15. Decedent's E	Year or Dates:	16a [)eredent's Hs	ual Occupation			of Business/Ir	
piet	- 2	(Specify only highest gr	ade completed)		Give kind of w life. DO NOT	rork done during most of w use retired)	vorking		off Site	
Completed	5	Elementary/Secondary (0-12)	College (1-4or 5+)	V	ault Sp	ecialist_			Prote	
Bec	ט '	17. Father's Name (First, Middle, Last)				ame (First, Middle	, Maiden S	umame)	
P)	Earl Jones				Dorot	hy Fal	oian		
		19a. Informant's Name/Relationship			_	ss (Street and Number or I		ONE STREET		p Code)
	_	Robb Anderson 20a. Method of Disposition	(spouse		052 Kir	ngs Road, Par	sadena, I	ND 211	22 ition - City or T	eum State
	4	1 Burial 2 Cremation 3		20b. Place of E cemetery,			Ty ^{Date} 11			
ķ	-	 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lies 		Metro (ory Inc.	2005 Stallin	Balti	more, r	Maryland Home, P.A
		Volume 1	Ablin	-		1 Mountain I	Road. Pas	sadena	. MD 21	11 <i>22</i>
Ė	1	23a. Part1. Enter the disease, or con	aplications that caused th	Nooth Door			, , , , , , , , , , , , , , , , , , , ,		,	
ı		snock, or neart failure. Light only		e weath. DO NO	t enter the mo	de of dying, such as cardi	ac or respiratory a	arrest,		Approximate
		Immediate Cause (Final				ode of dying, such as cardi			0000	Interval Between
				sive Ath	nerosc1	de of dying, such as cardi			ease	Interval Between
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			Chats of Maryland / Department of Health and Mo	_	_	
			State of Maryland / Department of Health and Me	ınıaı mygler	ie	
_			Registrar Certificate of Document	Reg. I	7005	23.160
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Pay Year	S. Une priligation
	/Medic	al	Margaret M. HITENDURGER	JULY	5 200	3.0.0/p,"
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deatl	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8	Date of Righ	BALTI	
	Funeral Director		1 M 2 F Months Days Hours Min.	Date of Birth Month, Day, Yes	y ma	nplace (State or Foreign untry)
			Usual Residence of Decedent	0 1 1 0) 1 ////T	THOM
	yland now		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mar 9-fet	io	MD BALTIMORE PARKVILLE			1 □ Yes 2 QNo
	th the	Funeral Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Co	untry?
	23a d	a	2503 Lakewood Ct. 21234		USH	
	r dea	nei	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Cuban, Mexican, Puerto Richard Cuban, Puerto	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
36	or it	by Fi	1 Never Married 2 Married 1 Yes 2 M No If Yes, Give 1 Yes 2 No Specify: Year or Dates:		Specify: j	2:40
8	filed within 72 hours after death with the Maryland Hygiene. other then "netural", or Items 23a or 28e-f ehow ent, the Modeal Exempler must be multified at	pa pa	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16b	. Kind of Business/	Industry
5	in 72 in 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	7		,
7	with iene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)	α	+ none	
0	filled t Hyg other	Be C		First, Middle, Maid	len Sumame)	
a	ald be fenta rked tic ev	To B	Educard Bannon Chice	Fillin	n	
Maryland 21215-0036	12 should be f and Mental I 7 Is marked of reumetic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural I	Route Number, Cit	y or Town, State, Z	(ip Code)
	and 2 ealth a m 27 I		Kobert Alten Durger 2503 Lakewood C	t. Par	Zville V	MD arasy
ore	es 1 a		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	te / 20c	Location - City or	Town, State
<u>Ĕ</u>	Pages ment of I ent: If its ury or o		'4 Donation 5 Other (Specify) Fartward Circles 17-18-1	05 PC	arkvill-	e MO
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23a or 28e-f ehow any injury or other treumetic event, the Modeal Examiner must be nutified at once.		21. Signature of Funeral Service Licensee	TIMORE	5, MO 2	1234.
Ш	<u> </u>		Genberry C. Jaylotter EVANS FUNERALC		8800 HA	REPORD RD.
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)			
	/Medical Examiner		Due to (or as a consequence of):			
		-	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):			
	nted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
<u>,</u>	le be executed ysician and e burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):			
760,	ite be executed iysician and he burial-transit	cal	d			
68	tifica ng ph as th	Ved	IS SECULAR.			
Вох	death certifica e attending ph ed for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of del	ivery Day Year
	es that the death certificat igned by the atlending phy be detached for use as th	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown 1 ☐ Unknown		I WOTEN	Suy Tour
P.O.	The law requires that the ste has been signed by th bage 2 should be detache	Ph	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ds,	signe	l by		1 🗆 Yes	2 No 3 Pr	obably 4 Unknown
Š	w require been sign	Completed		24a. Was an	24h Were au	topsy findings available
Rec	has ge 2	m		autopsy performed	? prior to death?	completion of cause of
a	n: Ti ficate or, pa			(Check only one)	No 1 Yes	2 No
of Vital Records,	tending Phyeicien: The lav leath. tor: After this certificate has the funeral director, page 2	To Be			6 X]Other (Spec	city) HOSPICE
10	g Phy er thi			3d. Describe how i		200220
0	Attending in death.	atio	1 Natural 5 Pending (Montal, Day Year) Injury 2 Accident investigation M 1 Yes 2 No			
Division	of or Attendate after death Director: /	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 6 ☐ Could not be determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)	3f. Location (Street City or Town, S	and Number or Ru tate)	ıral Route Number,
	itel or irs afte rel Dir led in l					
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) 2 Medical Examination On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	To the within 2 To the Complet	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29d.	Date signed (Monti	h, Day, Year)
1	Z .≱ E 8		D43725		7/14/	05
7	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		-/ //	
	10		DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM,	MD 21093		
	Sta	ate	31. Date liled (Month, Day, Year) 32. Registrar's Signature			
	Regist	rar	JUL 1 5 2005 Describe Special			
DI	IMIL 17 Co. 170	001				

			1 - For State Registrar	State of M	aryland / Dep	partment of F			iene 9. NS NN 5	22161
			1. Decedent's Name (First, Middle,	Last)				2. Date of Deat	th	3. Time of Death
	Physici /Medi		Anthony	J. Andre	ejak Jr.			July	10 2005 Year	11:45pg
	Examir		4a. Fecility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Death		4c. County of De	ath
			302 Sassafra	as Road		Essex			Baltin	ore
	Funeral				e (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign
	Director		217-18-5251	1 2	79 Yrs.			Feb.1	7,1926 🕅	lAryland
	and * □		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits
	Aaryli F sho	ō	MD Balt:	imore	1	Essex				1 Yes 2 XNo
	28a-	Director	10e. Street and Number			10f. Zip Code		14	On Citizen of latters of	
	with 3a or		302 Sassafra	as Road		212	221	1	0g. Citizen of What C USA	ountry?
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13				14. Race - Am	erican Indian
9	or iter		1 ☐ Never Married 2 ☑ Marrie	Armed Forces?	No	. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Wh	
9	ral', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. od other than "natural", or terms 23a or 28a-f show event, The Medical Exerting charton notified at	Completed	15. Decedent's (Specify only highest	Education	16a. Dec	edent's Usual Occup	ation	kina	16b. Kind of Business	s/Industry
2	within ene. than "	nple	Elementary/Secondary (0-12)	College (1-4or 5)+)	e kind of work done of DO NOT use retired	d)	Wilg	C.P.Fle	et
2	e filed within al Hygiene. i other than '		12th		M€	chanic				
and	be fill be did be did be did be of our	Be	17. Father's Name (First, Middle, La				18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
3	2 should be and Mental is marked or raumatic ev	P	Anthony J.	-				Symbors		
Maryland	d 2 sl th an 7 ls r traur		19a. Informant's Name/Relationshi Hilda Andreja						City or Town, State,	Zip Code)
	1 and Health tem 27		20a. Method of Disposition	IK / WITE	20b. Place of Disg	2 Sassaf	.ras koa		LMORE MD 20c. Location - City or	Town State
JO L	Pages nent of int: If It		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Bayvie	ematory or other place WCremato	orv 7/1		Baltimore	
Baltimore,	# 문원를		21. Signature of Funeral Service Li			22. Name and Addres				
ñ	permi Depa Impo any is		X Tess	16	Olas		Co	nnellyF	uneralHo	meofEssex
	Priysician /Medical Examiner		23a. Pan1. Enter the disease, or conshock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	a Acuto Due to (or as	the death. Do not enter. Renal I a consequence of): Vascula	rter the mode of dyin	g, such as cardiac	or respiratory arre	ore MD 2	Approximate Interval Between Onset and Death Weeks
		Jer	Sequentially list conditions, it any, leading to influed the cause. Enter Underlying Cause (Disease or injury	Dua to (or se	a consequence of):			ease		Weeks
V	cute	Examiner	that infliated events	С.	Tubula					Weeks
8760,	The faw requires that the death certificate be executed that been signed by the attending physician and age 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a Acute	e Ventrio	cular Fa	ilure			Weeks
Box 6	n certific anding p use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery
P.O. B	that the death certific ed by the attending p detached for use as	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 4□Pregnant at 9□Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
σ.	res that igned by be deta	УРЬ	Part II. Other significant condition	s contributing to death bu	it not resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	quires n sign	d by	Cerebellar Va					1 ☐ Yes	s 2□No 3□Pi	obably 4 Unknown
Ö	w requires been slashould?	Completed	Upper Urinary		•	•	-	24a. Was an	24h Wara a	itopsy findings available
Re	The tav te has age 2	duo	Hypertensive			,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		autopsy perform	egt? prior to death?	completion of cause of
ta	an: tifical tor, p	Φ	25. Was case referred to medical	Replitosei	.CIOSIS		26 Place of Best	1 Yes 2	No 1 Yes	2 Y No
\geq	ysici is cer direc	To B	examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	nt 3 DOA Othe		14. 4	nce 6 Other (Spe	cifu)
0	Attending Physician: or death, ector: After this certifici by the funeral director,		27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time (28d. D. scribe hov		ony)
0	endir sath, or: Af he fur	atic	1 Accident 5 Pending investigat	ion	, out,		res 2□No			
Division of Vital Records,	or Att	Certification;	3 Suicide 6 Could not 4 Homicide determine		ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	pital burs a eral C		29a. Certifier 1 Certifying	Physician, To the best of	for the state of the	the second second				
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical	one)	Physician: To the best of aminer: On the basis of and manner stat	examination and/or it	th occurred at the tim	e, date and place, vinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To To	Σ	29b. Signature and title of contifier	W. 7	110	29c. License			d. Date signed (Mont	
1		1	Milly	V/Cll	exy "		1749		July 12,	2005
	10		30. Name and address of person wh			,				
	Sta	10	Dr. Allen Rei		4 East	Rolling	Crossro	ad Ste	307 Balt	. MD
	Sta		JUI 1 5 200!	1 18 00 A	M. Works	Las				

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARTE ALLMOND /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UNION MEM HOSPITAL BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 F Director 227-26-0369 Yrs 08/02/1922 VA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "naturat", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Completed by Funeral Director 1¥ Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2819 W. LAFAYETTE AVENUE 21216 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. snt: if item 27 is marked other than "naturat", or items 23. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 ö́ Specify:BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSES AID HOSPITAL/HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NOAH LEE WILLIAMS ARLEVIA **JOHNSON** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any injury or other transone. DAVID ALLMOND 2819 W. LAFAYETTE AVENUE, BALTO., MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ARBUTUS MEM * 4 ☐ Donation 5 ☐ Other (Specify) 7/18/05 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS STREET, BALTO., MD 21217 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 00010 **Physician** WE MONT. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 → No 9 Unknown 9 Unknown cate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NFECTION Completed 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has autopsy performed? 2 140 1□ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No. Other: Certification: To 1 | Inpatient 2 | ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 47123 mouna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) On 100 MIZING ALTION ORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Physicia		I. Decedent's Name (First, Middle, La	ast)	aryland / Dep 27,28a-f			2. Date of Dea Month		3. Time of Death
/Medica		ALVIN E.	AYDLETT				JULY	11, 2005	3:05 P ^M
Examine		a. Facility Name (If not institution, gi 42 SOUTH ATHOL A			4b. City, Town, or BALTIM	Location of Dea		4c. County of Deat	th
Funeral Director		215-46-9370	Sex 7. Ag 1X M 2□F	58 Yrs.	Months Days	If Under 24 Hr Hours Mir		9. Bird 12, 1947	thplace (State or Foreign buntry) MD
>	⊢	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	Location				10d. Inside City Limits
28s-f ehow	.			DATTT	MODE				12 ves 2 □ No
28a-	Director	MD 10e. Street and Number		BALTI	10f. Zip Code			10g. Citizen of What Co	ountry?
23a or	اڌ	42 N. ATHOL AVE	NUE		2	1229		USA	
al', or iteme	by Fur	11. Marital Status 1 ☐ Never Married 2 ★★ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 XXes 2 [,	B. Was Decedent of H If Yes, specify Cuba 1 Yes 2XXIo	ispanic Origin? (In, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	Black, Whit	
of Health and Mental Hygiene. Item 27 is marked other than "netural, other traumatic event, the Medical East	Completed	15. Decedent's 6 (Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or	5+) (Giv	edent's Usual Occup to kind of work done DO NOT use retired	ation during most of w 1)	orking	16b. Kind of Business	ICKEY SCHOOL
tygier her ti		17. Father's Name (First, Middle, Las	3		ECURITY	18. Mother's Na	ame (First, Middle,		CKET BOHOOT
od of	ă	ELDEN E. AYDLET					HAMILTO		
mark matic	ြ	19a. Informant's Name/Relationship		19b. Mai	iling Address (Street	and Number or F	Rural Route Numbe	er, City or Town, State, a	Zip Code)
Ith ac 27 is r trau		MARY AYDLETT/WI		42	N. ATHOL	AVE. E	BALTIMORE	, MARYLAND	21229
t Hea Item othe	*	20a. Method of Disposition		20b. Place of Disp		-	Date	20c. Location - City or	
		1 Donation 5 Other (Spec			N FOREST		-19 - 05	OWINGS MII	LLS, MD
Department Important: I any Injury o once.		21. Signature of Funeral Service Lice	ansee		22. Name and Addre			MORTON & SOMORE, MARYI	ONS F.H., INC LAND 21217
	Exa	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (or as	a consequence of): a consequence of): a consequence of):					
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	/Medic		Melvin L. 4a. Facility Name (If not institution, g		ber)		4b. Cîty,	Town, or	Location	of Death	oury		ounty of Death	1.00	
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	Funeral		Social Security Number 6	Sex 7	. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 0Ct. 04	Year)	9. Birthp	place (State or	r Foreign
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Maryland	2 should be and Mental is marked o	To Be	Chris J. B	raun		105 Mail		(Street 6	Ara	abel		gab1	е	Code	
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imo	Page: ment o ant: If ury or	- 1	1 Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe	cify)	Mt.	Carme	1 Cem	eter	у	20	05 14	Pasade	ena, Ma	ryland	1
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)	a. Due to (o	ch line.	uence of):	er the mod	st	g, such as	cardiac	Syno	est, Lron	ne	Approximate Interval Betwoonset and D	ween
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ita		Bec	25. Was case referred to medical examiner?					7.7		e of Deat	h (Check only o				
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	->-0		1 Ruth	122		10		H 55	5542			July	15, 200	15	
-	20		30. Name and address of person w					Anna	polis	s, ME	21401				
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUL 1 5 20		ngistrar's Signa										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. item#16b, perFh, C845, 7/15/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2 0 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 07 homas 0326AM CIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Muryland Medical Center University NIA BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)

53 Yrs. Birthplace (State or Foreign
Country) **Funeral** 218-62-9730 Days 1 X M 2 □ F Director Usual Residence of Decedent with the Maryland 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ZYes 2 □ No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 5 Items 23a ALTIMORE STREET death v Completed by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2ÅNo Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MD Reproduction College (1-4or 5+) Elementary/Secondary (0-12) 1 + HGRADE ER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SCNNETI THOMAS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. 841 CWIFE LESSIE BENNETI TIMORE ST. BALTO, MD, 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State CEMETERY 7-20-05 ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN JR. FUNERAL HOME "ULTON AVE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician emorrhage intra abdominal /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Cor anoma if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner transit The law requires that the death certificate be executed as the burial-to Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No Division of Vital 1 ☐ Yes 21**Z** No 1 Tyes To the Hospital or Attending Physician: director, 25. Was case referred to medical exampler? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide hours after within 24 hours a To the Funeral D 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47322 3/05 ar) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEDDI FAGUE Mid S. GREDNE ST. BALTIMIRE di) 22

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

15

2005

32. Pogistrar's Signature

21201

			For	State of Maryland	/ Departmer	nt of Health and	Mental Hygi	ene	
			= State Registrar		Certificat	te of Death	Re	200 CON.B	23166
	Physici		1. Davedont's Name (First, Middle, Last)	rrest B	004)	2. Date of Death Month	Day O.5 Year	5. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and nymber)	Ap City.	Town or Location of Oea	ith	4c. County of Death	7
	Funeral Director		119-19-6114	M 2 F	birthday) If Unde Yrs. Months	r 1 Year If Under 24 Hr Days Hours Mir		Year) 4 9. Birthy Could -24 Ma	place (State or Foreign ntry)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location	700)			10d. Inside City Limits 1
	with the	i Director	10e. Street and Number 140 7 8 - 2 944	Stroot	10f. Zi	0 Code	10	g. Citizen of What Cour	ntry?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Items 23a or 28a-f show or other traumatic svent, Ite Medical Estructuration halliad at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give	13. Was Dece If Yes, spe	dent of Hispanic Origin? (ority Cuban, Mexican, Pue 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	na na		15. Decedent's Educ (Specify only highest grade		6a. Decedent's Usu (Give kind of wo	ork done during most of w		6b. Kind of Business/In	idustry
	filed within Hygiene.	Completed	Elementally/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Insp	rector	ame (First, Middle, M	Manutz	ictuena
Maryland	should be find Mental Find Men	To Be	Oliver J.B	00H		Mar	Tha (cates	5
e, Mar	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent; if Item 27 is marked other than any injury or other traumatic avent, Item Monce.	,	Jonathan F.	Booth	29068	s (Street and Number or F	re Ba	HO.MD &	21216
Baltimore	Pa men ant ury		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	e of Disposition (Na etery, crematory or o	Tomotory	7/15/05/	Oc. Location - City or To Balto · M	D State
Balt	permit. Pa Departmer Importent: any injury once.		21. Signature of Funeral Service License	hi	2 Name a	ad Address of Facility C Mation S Political Address of Facility C	ional Pil	2, £A.40.	BUTO.MD 21229
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death. I e cause on each line.	po not enter the mod	de of dying, such as cardi	ac or respiratory arres	it,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen	nce of):	W+P-11			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	nce of):	T PSON			
8760,	cate be executed physician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a consequen	nce of):				
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Vital		BeC	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one		
of V	Physicien: this certific ral director,	L _O	1 ☐ Yes 2 No		VOutpatient 3☐ D		Home 5 Aresider		<i>(y)</i>
ion	Attending P r death. ector: After t by the funera	atlon;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe hov	r injury occurred	
Division	tel or Att	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factor	ry, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical Certification:		ician: To the best of my knowle ler: On the basis of examination and manner stated.					
)	within To the comp	M	29b. Signature and title of certifier	2/1/1	M29	Oc. License number	F49 29	d. Date signed (Month,	Day, Year)
	1,1		30. Name and address of serson who co	mpleted cause of death (Item 23	3a) (Type, Print)	1206	York Ra	P. Syrtel	202
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrat's Signatur	freder	so cuth	enille,	2/2 2	1093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jul **Physician** Elizabeth econ 2005 e/10 /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** limonium ella If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Y 9. Birthplace (State or Foreign 7. Age (In yrs. 5. Social, Security Number last birthday Year. **Funeral** Days Hours Min 05 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examinat must be notified at 1 ☐ Yes 2 No Baltimore CockeySVII Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number S, 21030 U Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 🔊 No Specify: Whit Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced end Mental Hygiene. Is marked other then "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Legal eccetai 12 17. Father's Name (First, Middle, Last) me (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be 1 nent of Health end Mental I James ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ockersville Basley eron item 27 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages
Department of
Important: if it
eny injury or o Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner for use as the burial-transit The law requires that the death certificate be executed the attending physicien and Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🛣 No 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an 2 No 1 Yes Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2X No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 1 Tes Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Division 1 X Natural 5 Pending 1 Tes 2 No after death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a, Certifier Medicai (Check only one) completely

ELIZABETH BERGERON

To the I Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of pertifier

DR. TARIQ MAHMOOD

2

2005

ORIGINAL

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

143725

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death . Decedent's Name (First, Middle, Last) Day Month **Physician** Thomas Stanley Broda 1:36 14, 2005 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 27 Riverside Road Essex If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Sept. 8, 1946 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 215 46 6294 58 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or then "natural", or items 23e or 28a-f show 1 Yes 2X No Be Completed by Funeral Director Maryland | Baltimore Essex the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21221 27 Riverside Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after to ment of Health and Mental Hygiene. and the then "natural", or iter ant: if item 27 is marked other then "natural", or iter any or other traumatic event, it we would. 1XYes 2□No If Yes, Give Year or Dates: 1966/73 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber Construction 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leona Schultz Frank A. Broda ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Riverside Rd. Baltimore, Maryland 21221 JoAnna Bowman (Sister) 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Spurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest, MD. permit. Page Department c important: if eny injury or onge. MD. Veterans Cemetery 7/22/2005 ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 21. Signature/of Funeral Service License 9 Durkousfe 1407 Old Eastern Avenue Essex, Md. 21221 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Extensive stage small call long 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit Due to (or as a consequence of): Box 68760. The law requires that the death certificate be the IF FEMALE: esn. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ð Ashestosis 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 1 ☐ Yes 2 No certificate 2 BNo Division of Vital o the Hospital or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 70 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide the Funaral Di the Funaral Di mpletely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 14, 200 S 023809 Lusten hus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greeno St., Baltmore, MD 21201 Greenelsaum L. Austra Doyle, M.A. ch., 31. Date filed (Month, Day, Year)

JUL 1 5 2005 32. Registrar's Signature 204 Registrar

		1 = For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of He rtificate of D			ene ^{3. No.} 2.0.0	F 0.5.
Physic		Decedent's Name (First, Middle, Last, Frederick Charle		us			2. Date of Death Month June 27,	2005	32 time of Death C
/Med Exam		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of D	
xan		2038 Poplar Rid	ge Road		Pasadena	a		Anne A	cundel
Funera Directo		5. Social Security Number 6. Security Number 213-26-9547	7. A	ge (In yrs. last birthday) 75 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Feb 1, 1	9. (9. (9. (9. (9. (9. (9. (9. (9. (9. (Birthplace (State or Foreign Country) ryland
p ,	7	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
aryla ehov	=			roc. ony, rown or E					1 ☐ Yes 2√☐ No
he M	Director	MD Anne Ar	undel		Pasadena 10f. Zip Code		100	g. Citizen of What	
with a or			D 1			122	100		Country
eeth	era	2038 Poplar Ridge	12. Was Deceden	t Ever in U.S. 13.	Was Decedent of His		ecify Yes or No-	USA 14. Race - A	merican Indian,
ours elter deeth with the Marylan ral', or Iteme 23a or 28a-f ehow Examirer must be coulfied at	Funeral	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 ∑	?	If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, W	hite, etc.
urs e	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates		1 ☐ Yes 21 No	Specify:		Specify:	white
72 hours efter deeth with the Maryland "natural", or Iteme 23a or 28a-f ehow olical Examiner must be collified at	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa	tion	ing 16	3b. Kind of Busine	ss/Industry
C * 0	ple	Elementary/Secondary (0-12)	College (1-4o	life.	DO NOT use retired)		9		
	SO.	7	0	comp	uter prog			chemic	al_company_
9 70 - >	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma	viden Sumame)	
should be nd Mental marked o	10	Louis Paul Bauha					Ann Meyer		
2 sh and is m		19a. Informant's Name/Relationship (Ty Margaret Bauhaus/			ng Address (Street a				
and lealth m 27			spouse	205 Place of Disp	Poplar R				1122
Peges 1 and 2 should b nent of Health and Ment. int: if item 27 is marked iry or other traumatic e		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify)	lemoval from State	camatary cra	matory or other place		<i>Date</i> 20	c. Location - City	or rown, State
permit. Pege Department Important: If any injury or		21. Signature Funeral Service Lice is Ronald		ector St	2. Name and Address cate Anato altimore,	my Board		Baltimore	Street
Physician /Medica Examine physician and physician and the printing-transit	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence of): s a consequence of):	ymphi	cyhic	Cenkein	uá	Interval Between Onset and Death
law requires that the death certificate by as been signed by the attending physic 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of o	lelivery Day Year
es tha igned be del	by P	Part II. Other significant conditions con	/	-	inderlying cause give	n in Part I.	23e. Did toba	cco use contribute	to the cause of death?
w require been sig	ed	renal for	aslure	2			1 🗌 Yes	2 No 3	Probably 4 □Unknown
e he	Completed	√					24a. Was an autopsy performe	prior t d? death	autopsy findings available o completion of cause of ? es 2 \sum No
sicien: Th certificate irector, pag	a	25. Was case referred to medical				26. Place of Death	h (Check only one)		
S S	0 8	examiner?	lospital:	ient 2 ER/Outpatie	nt 3 DOA Other	C 4 □ Nursing Ho	me A Residence	ce 6 ☐Other (S)	pecify)
I or Attending Physatter death. Director: After this I in by the funeral di	atlon: T	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	jury 28b. Time o ay Year) Injury	Work*	at ? es 2 □ No	28d. Describe how	injury occurred	
after death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In building, e	njury - At home, farm, st atc. (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or State)	Rural Route Number,
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical C	29a. Certifying Physics (Check only one)	sician: To the bes ner: On the basis and manner s	t of my knowledge, deat of examination and/or in stated.	h occurred at the time vestigation, in my opi	e, date and place, inion, death occurr	and due to the caused at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
To the within 2 To the complet	₹	29b. Signature and title of certifier	0		29c. License			I. Date signed (Mo	
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		30. Name and address of person who co	empleted cau of	death (Item 23a) (Type,	Print) Ritchie	Hay se	ite 134	Parid	los lenal102/12
S	tate	31. Date filed (Month, Day, Year)	327 Regis	trar's Signature	will !	0			

		•	For State Registrar	State of I	Maryland		rtment <i>tificate</i>				ental F	Hygie Reg		005	23170
			Decedent's Name (First, Middle, Last)							2. Date of Month	Death	Day	Year	3. Time of Death
	Physicia /Medic	al	ASA CARLIS BABER								JULY	9, 2	005		9:20 A.M
	Examin		4a. Facility Name (If not institution, give 322 VALE SUMMIT SOUTH				LAU	REL	Location of				4c. County	ARUNE	
	Funeral Director		243-42-3601	x 7.	Age (In yrs. Ia 72	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, AUG.	Birth Day, Y 9, 1	932	9. Birtho Cour NORTE	lace (State or Foreign try) CAROLINA
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d. Inside City Limits
	Mary f sho	to	MD ANNE ARUI	NDEL	LAU	REL									1 ☐ Yes 2 No
	or 288	Director	10e. Street and Number				10f. Zip	Code				10g	. Citizen of	What Cour	ntry?
	ath wi	rai	322 VALE SUMMIT SOUTH		- E !- !! O	40.1		724	annia Ori	inin2 (Cnn	aifu Vaa a		USA	ce - Americ	en Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 271s marked other than "natural", or Items 23a or 28a-f show or other traumatic avant, it e Mcdical Examinat must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	as? □ No	i	Was Deced f Yes, spec 1 ☐ Yes 2		Specify:		Rican, etc.	140-		ck, White,	etc.
20	72 hou	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)		16a. Deced	kind of wor	k done d	luring mos	t of workir	ng	16	b. Kind of B	usiness/In	dustry
21	ne. han "u	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	DO NOT US RAL CON	e retired,)				MASS	S TRANS	SIT
7 7	Hygie Hygie ther th	CO	12 17. Father's Name (First, Middle, Last)	ש		CLIVIT	CAL COI	TROL			(First, Mic	idie, Ma	iden Sumar		,,,,
<u>a</u> n	lid be lental ked o ic ava	To Be	RAYMOND J. BABER						BERT	HA L.	SEAWEL	.L			
Maryland 21215-0036	should and Men s marke sumatic	-	19a. Informant's Name/Relationship (T				•						ity or Town		Code)
Σ	s 1 and 2. of Health ar itam 27 Is		HELGA I. BABER / WIF	E	20h Pir	322 ace of Dispo			5001		ate		AND 207		wm State
lore	ges 1 it of H if ital		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I		ite ce	metery, cren	natory or or	ther place	θ)	7/12/			ELKR I DO		
Baltimore,	permit. Pages 1 and Department of Heall Important; If itam 2 any injury or other once.		21. Signature of Funeral Service Licens		MEAL	OWR I DGE	. Name an	d Addres		ty FL	ECK FL	JNERA	L HOME	, INC.	
	40244		23a. Part1. Enter the disease, or comp	lications that cau	sed the death.	Do not ent								1112 201	Approximate Interval Between
	Physician		shock, or heart failure. List only o		n line. CELLULAR	CARSIN	ΟΜ Δ								Onset and Death
	/Medical		disease or condition resulting in death)	a	as a consequ		UPIA								
ı	Examiner		Sequentially list conditions,	b											
2	ed	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ence ot):									
6	al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consequ	ence of):									
8760,	cate be executed oblysician and the burial-transit	dical	(d											
9	certifical nding phy use as th	Medi	IF FEMALE:												
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ر. ص	res that the igned by th be detache	by Ph	Part II. Other significant conditions co	ntributing to deat	h but not resu	lting in the u	nderlying c	ause give	en in Part I	l.					ne cause of death?
rds	w requires been sign should be										1	Yes	2 No	3 Prob	ably 4XXUnknown
Vital Record	The law ate has b page 2 s	Completed									a	Vas an utopsy erforme s &	d?	Were auto prior to co death? 1 \(\subseteq Yes	psy findings available mpletion of cause of
Vita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	25		(Check or		A [] (1)		
ō	Phys this ral din	To It	1 Yes 2X No 27. Manner of Death	28a. Date of	Injury	R/Outpatier 28b. Time of		8c. Injury	/ at		-		injury occur		y)
lon	Attanding Phyrdeath. sector: After thi	tior	1 X Natural 5 ☐ Pending investigation	(Month,	Day Year)	Injury	м	Worl	<br Yes 2□	No					
Division	= 2 te o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	Zoe. Place of	Injury - At hor , etc. (Specify)	me, farm, str	reet, factory	, office		2	28f. Location City or	on (Street Town, S	et and Numi State)	ber or Rura	il Route Number,
_	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) (Check only one) (Check only one)	vsician: To the boinar: On the bas and manne	is of examinati	vledge, deat on and/or in	h occurred vestigation	at the tim , in my of	ne, date ar pinion, dea	nd place, a ath occurre	and due to ed at the ti	the caus	se(s) and m and place,	anner as s and due to	tated. o the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	C	000	_	290	. License	e number			29d	. Date signe	ed (Month,	Day, Year)
	V		hand	00	200	2X	D	23743					JULY 11	, 2005	
	107		30. Name and address of person who o			23a) (Type, GREENW		TED V	RIVE +	#205	CREENE	FIT	MARVIA	ND 207	70
	Sta	ate -	MARTIN D. WELTZ, D.O. 31. Date filed (Month, Day, Year)	32 Beg	mtrar's Signat	ure	_		1 V L 7	2009		,		207	
	Regist		JUL 15	2005	PREMI	H A	Speed								

sician and burial-transit The law requires that the death certificate be executed Box 68760, P.O. I Division of Vital Records, 80 After death.

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year 7:27 a.m Oliver Bailey 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sinai Hospital Balto If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months **X**☐M 2☐F 76 Yrs. Va Director 224-30-5768 7-16-1928 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10a State 10h Counts 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Md N/A Balto Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2409 St Stephens Court Apt 1 D 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 No Specify: Specify **Black** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Union Realty 3rd grade N/A Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hugh Bailey ပ Vonnie Massenburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any injury or other trangang. 2409 St Stephens Ct Apt 1D Balto, Md 21216
of Disposition (Name of Date 20c. Location - City or Town, State <u>Edna Bailev - Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 7/20/2005 Owings Mills, Md ig ature of Funeral Service Doensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, MD 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATHENOSCLEROTIC HEART DIJEAGE disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☑ No fo the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 □ No 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 1 Yes 2 No 2 Accident investigation Director: 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral L 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number CHC D0029250 JULY 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAL HOSPITM OF BALTIMORE B UNDESS, MO 31. Date filed (Month, Day, Year) JUL 1 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

amend 10a,18 per F.H. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			Certifica	te of Death		leg. No.	ane d	201
Physician	1. Decedent's Name (First, Middle, Las	BROWN			2. Dete of Dee	Day_	Year 3. Z	ime of Clear
/Medical	DELIGH 4a Fecility Neme (If not institution, give			th City Town or	Location of Death	07	2005 (1255
Examiner	A A /	TON PEDINTRIC	HOSPITA	0	1	4c. County	A A	
Funeral	5. Sociel Security Number 6. Se	ex 7. Age (In yrs. las	st birthdey) If Und	er 1 Year If Under 24 Hr	s. 8. Date of Birt		9. Birthplace (State or For
Director	N/A 11	□ M 200 F	Yrs. Month	Days Hours Mir		K Year) 2のつご	MARYCO	NO
	Usuel Residence of Decedent							
show	10a. State 10b. County	10c. City,	Town or Location					side City Li XYes 2 ⊡
28a-1 potifile	Maryland N/	1		10re				D 165 2L
there was not a state occur with the many and then then "natural", or theme 23s or 28s-1 show and, the Medical Expense. must be notified at completed by Funeral Director	10e. Street end Number 911 N	Rutland Ave	107. 2	(ip Code 2120)5	log. Citizen of	What Country?	
era	11. Maritel Status	12. Was Decedent Ever in U.S.	13. Was Dec	edent of Hispanic Origin? (Specify Yes or No-	14 Rad	ce - American Ind	ian
or item miner Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	nto Rican, etc.)	Bla	ck, White, etc.	,
Exam by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Yes	2X No Specify:		Specif	RIAC	Y
Mentel Hygiene. riked other than "natural ritic event, tra Medical Exitic event, Tra Medical Exitic event, To Be Completed b	15. Decedent's Edi (Specify only highest grad	ucation	16a. Decedent's Us	ual Occupetion	odeina	16b. Kind of B	usiness/Industry	
ne Ne	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	rork done during most of wo use retired) A	, and		Λ	
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© €çē	17. Father's Name (First, Middle, Last)	الما الما الما	(18. Mother's Na	me (First, Middle,	ana Bro	n <i>e)</i> WN	
h end Mentel 7 is marked o traumatic eve To Be	19a, Informant's Name/Relationship (T	tawkins	10b Mailing Addre	cs (Street and Number of E		2 TV	Ctata 7in Carlo	
alth en 27 is i	Mrs Frica L	3 LALIC	1/-17 /	6 17		I A	, State, 21p Code)	20
운동종	20a. Method of Disposition	20b. Pla	ce of Disposition (N	ingtora t	Date Date	20c. Location	City or Town, St	ate
0 = b	1 ⊠ Burial 2 □ Cremation 3 □I 4 □ Donation 5 □ Other (Specify,	Hemoval from State	netery, crematory or		7/15/2005		e done	1
Depertmant mportant: I any Injury c ance.	21. Signature of Funeral Service Ligens	1.11	22 Name a	Sabyland and Address of Fecility			SHUWY	16,11
en en en en en en en en en en en en en e	1 Jarons	y Ku	Josep	h L. Russ / W. North	Funeral tue. Bo	Home	P.A.	. , /
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death.	Do not enter the mo	de of dving, such as cardia	c or respiratory ari	est.		L/ 6 ximate
nysician	shook, for heart failure. List only o	ne cause on each line.		101-11 0-12			Interv Onset	al Between and Deat
Medical	Immediate Cause (Final disease or condition	VENTRICULAR	SEPTI	DECECT	-tag		12	OISTA
xaminer	resulting in death)	a. VENTRICULAR Due to (or a	as a consequence of):			279	C),U, N.
it line		b. TRISOMY	18				51	אדלום
n end iel-transit Examiner	Sequentially list conditions,	Due to (or a	as a consequence of):				
physician s the burie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C		166				
physicia as the bur edicai	that initiated events resulting in death) Last	Due to (or a	is e consequence of)	:			į	
nding phuse es t		d					1	
d by the attendilletached for use	Part II. Other significant conditions cor	ntributing to doubt but not requisi	in a la sha ua dadula a	anna airea ia Badi	not Dida		- A-15	
y the	Tarri. Other significant conditions con	Tributing to death but not result	ing in the underlying	cause given in Part I.	230. Did (0	mecco nae co	ntribute to the ca	euse or a
20 20 20 1					1 D V	as all No	3□ Probably	4 □ Unk
aned be determined by PI					1 🗆 Y	s 2 No	3 Probably	4 □ Unk
en signed b buld be dett ted by PI					24a. Was a	n autopsy	24b. Were auto	opsy findir
as been signed by the attend 2 should be detached for us. 2 should be detached for us. Pleased by Physician/						n autopsy	24b. Were auto available	opsy findir prior to
has pa 2					24a. Was a	n autopsy ned?	24b. Were auto available completio	opsy findir prior to
ete has b paga 2 s	25. Was case referred to medical examiner?			26. Place of De	24a. Was a	n autopsy ned?	24b. Were auto available completio of death?	opsy findir prior to in of cause
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year MARY VIRGINIA BERG 2005 July 13 7:05a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Aug. 15, 1920 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Days Hours 1 □ M 2 🕅 F 84 Yrs Director 232~26~1387 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ahow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 4714 Meise Drive 21206 USA or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: <u>Ş</u> 1 ☐ Yes 2☐ No Specify: Specify: White 3X Widowed 4 □ Divorced natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne eny injury or other treumatic event, the Mode 2008. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade N/A Housewife Housekeeping~Own Home 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be Leonard Dayton Elsie Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis E. Berg (son) 4714 Meise Avenue Baltimore, Md. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 7-16-2005 Baltimore, Md. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home 21. Signature of Funeral Service Licensee e Hre 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY **Physician** FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 4S PIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examine The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 昼Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate I 2 No 1 Yes 2ENO 1 Yes Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Plnpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Matural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide a Funaral 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To tha 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO Tours D61773 14/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. CHARLES PAJAK 32. Regia ar's Signature 31. Date filed (Month, Day, Year) Registrar

				e of Mandand				•		•
			1 _ State	ate of Maryland	•	tificate of l		, ,		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncate of t	Deain		No. 200	5 23171
	Physicia	an	1. Decedent's Name (Pirst, Middle, Last)		1			2. Date of Death Month	Day Year	3Climetor beath
	/Medic		Indred Lou	recoter	a			Dely	12 90	22 0 190 m
	Examin	er	4a. Facility Name (If not institution, give street			4b. City, Town, or	r Location of Death		4c. County of De	ath
			Johns Hooking 5. Social Security Number 6. Sex	7.Age (In yrs. las	et highday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	contrac	re Cit
г	Funeral Director		1□M	2 T E	Yrs.	Months Days	Hours Min.	(Month, Day, Y	ear) 9. Bi	irthplace (State or Foreign
			212 14 8941 X	85				July 28 19	19 Bal	timore, Maryland
	yland Jow		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mar Fed	to	Maryland Baltimore	Baldw	in					1 ☐ Yes 2 ☐ No
	r 28s	irec	10e. Street and Number	1 Pricity		10f. Zip Code		10g	. Citizen of What C	Country?
	h wit	a D	12 Fork Springs Court			21013			USA	
	deal	Funeral Director	11 Marital Status 12. W	/as Decedent Ever in U.S.	13. V	Was Decedent of H	ispanic Origin? (Span, Mexican, Puerto		14. Race - Am	
9	or Ite		1 Never Married 2 Married 1	∐Yes 2∏XNo Yes, Give	i .	l ☐ Yes 2፟፟X No	Specify:	rican, etc.)	Black, Wh	iite, etc.
දූ	ural',	d by		ear or Dates:					Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or ttems 23a or 28a-f show the the Michell Ezindrer out to notified at	Completed	15. Decedent's Education (Specify only highest grade con	n npleted)	16a. Deced	lent's Usual Occupa kind of work done o	ation during most of work d)	ing 16	b. Kind of Busines	s/Industry
2	withir	ш		011ege (1-40r 5+)			3)		. 1	0 11
	lled v lygie lher t	ပိ	17. Father's Name (First, Middle, Last)	N/A	Housewi	ıre	19 Mathor's Name	(First, Middle, Mai	busekeeping	g-Own Hame
anc	ntai hed of	Be							den Sumame)	
Ë	hould d Me mark matic	2	John Mohr 19a. Informant's Name/Relationship (Type, P	leine)	10b Mailie	a Address (Ctrant	Myrtle Kue	hne al Route Number, C		7-0-1-1
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. The more are also as a second that then "natural", or thems 23a or 28a-1 show any injury or other traumatic event, the Machell Examiner must be notified at once.		Paula Waire	iunj						Zip Code)
	1 an Heal em 2 ther		20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name of		win, maryla	c. Location - City o	r Town State
Baltimore,	ages nt of t: It It		1 ⊈Burial 2 ☐ Cremation 3 ☐ Remov	al from State cen	netery, cren	natory or other plac	(a)			
틀	rtmertent		 4 □Donation 5 □Other (Specify) 21. 30 tule of Funeral Service Licensee 	Zion	Church		y 15 2005	В	altimore, N	Maryland
Ba	Department of the population o		21. Official of Puneral Service Cicensee	- Oborn		. Name and Addres ASSAhn Fune	ral Home In	C		
			23a. Part1. Enter the disease, or complication	os that caused the death	Do not ont	01 Belair	Road Baltim	ore, Maryla	nd 21236	Approximate
			SHOCK, OF HEART RAILUTE. LIST ONly One Car	use on each line.	DO HOL BHILE	ar the mode of dylin	g, such as cardiac (n respiratory arrest	•	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Archut	iad	0				moutes
Y	Examiner		, and the same of	Due to (or as a conseque	nce of):		0. 1.			
		-	Sequentially list conditions, b. —	Due to (or as a conseque	1-1C	art r	EURAGE	_		years
W.	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		100 01):	11-11				5
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760,	icate be executed physician and s the burial-transit	calE								
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X	nding use a	N/M		yes, outcome of pregnanc					23d. Date of de	elivery
.O. Box	that the death certific ed by the attending p detached for use as	by Physician/Med	in the past 12 months?	□Live birth 2□Fetal d □Pregnant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
0	t the by the ache	hys	9 □ Unknown 9	Unknown						
S, D	s tha	y P	Part II. Other significant conditions contribute	ting to death but not resulti	ing in the ur	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute t	to the cause of death?
ğ	w requires to been signer should be		Chronic obst	uchice	Pu	Coci	Disco	1 ☐ Yes	No 3□P	Probably 4 Unknown
Vital Record	aw requ s been 2 shout	Completed				(7	24a. Was an	24b. Were a	autopsy findings available
æ	The lav	mo						autopsy performed	death?	completion of cause of
ta	ilcien: Th certificate rector, pag	a)	25. Was case referred to medical				26. Place of Death	(Check only one)	10 10	3 20110
>	ysicien: nis certifica director,	To B	examiner?	al: 1 Inpatient 2 EF	NOutpatient	t 3 DOA Othe	er: 4 Nursing Ho	me 5 Residenc	e 6 Other (Spe	ecity)
0	Attending Physicien: The law requires that the death certifica rideath. rideath. sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the			a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work	at	28d. Describe how		
Division of	ath. r: Aff	atio	1 Natural 5 Pending 2 Accident investigation	(Werter, Day Your)	inquiy		Yes 2 □ No			
<u>×</u>	r Atte er de recto	tifle	3 Suicide 6 Could not be determined 28	e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or F	Rural Route Number,
	tel or A	Certification;		,						
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier Certifying Physician (Check only and and and and and and and and and and	n: To the best of my knowled	edge, death	occurred at the tim	ne, date and place, a	and due to the caus	e(s) and manner a	is stated.
	the Prin 24 the Front Prince P	ledi	0/10/	and manner stated.						
	To the within To the comple	Σ	29b. Signature and title of certifier			29c. License	e number	29d.	Date signed (Mon	th, Day, Year)
•	1		1 /de Jean			D4	7479		7/14/2	005
	4		30. Name and address of person who comple	ted cause of death (Item 2	3a) (Type, I	Print)	. 1			yland 21224
	U		Brack Beamer 5	505 HOPKIN	> Ba	Arien C	ircle t	saltmon	e Mora	yland 2/224
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re d	Cart o				1
6	Registr	ar .	JUL 1 5 2005	Blaus A	U. 16	THE SECOND				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

The State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** John A. Backus 12, July. 2005 10:24A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Nursing Home Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 20, 1908 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Yrs. 134-01-6709 96 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 Is markad other than "natural", or Itams 23a or 28a-t show other traumatic event, the Madical Examinations to rediffed at 1 XYes 2 ☐ No Director Maryland Montgomery Rockville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20850 106 Upton Street United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working

Effection of working) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 9088. 17. Father's Name (First, Middle, Last) Be Frederick Letts Backus 2 Elsie A. Auchinvole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah A. Backus/Daughter 106 Upton Street, Rockville, Maryland 20850 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Montgomery crematory or other place) July 14, 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Crematorium, Inc. 2005 ^ 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montromery Avenue Rockville, Maryland 20850-2805 Grie Ct Coro MO1386 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia Two Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 99 Congestive Heart Failure 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: / 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funaral D 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Musty gdas D31839 July 12, 2005 30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) Christopher C. Dunford, M.D. 615 West Montgomery Avenue, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registar's Signature JUL 1 5 2005 Registrar

			For	State of Maryland / De	epartment of Health and	Mental Hygier	ne
			1 - State Ragistrar		Certificate of Death	Rag.	~2005 23176
	Physici	an	Decedent's Name (First, Middle, La			Date of Death Month	3. Time of Death
	/Media	al	OPHELIA	BARNES		1 0	9 2005 12:35 AM
1	Examir	er	4a. Facility Name (If not institution, give Future Care, 5	412 Old Court	Randalls four	20	Baltimore
H	Funeral Director			lex 7. Age (In yrs. last birtho	Months Days Hours Mir		9. Birthplace (State or Foreign Country)
	D		Usual Residence of Decedent	7 10		\a 2 3	J VA
	ours after death with the Maryland ral', or Items 23e or 28e-f show Exsmirer rust be notified at	'n	10a. State 10b. County	10c. City, Town			10d. Inside City Limits
	28a-f	Director	10e. Street and Number	Dait	101. Zip Code	100	1 Yes 2 No Citizen of What Country?
	3a or		5605 Nesle	Avenue	21207	log.	U.SA
		Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
36	hours after tural', or Ite		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:	mo riican, etc./	Black, White, etc.
21215-0036	"natural",	Completed by	3 Widowed 4 □ Divorced 15. Decedent's E	Year or Dafes:	ecedent's Usual Occupation	16h	Kind of Business/Industry
215	within 72 ene. than "nat	piet	(Specify only highest gra Elementary/Secondary (0-12)	ide completed) (0	Give kind of work done during most of w fe. DO NOT use retired)	orking	oward County
	filed wit Hygiene other tha	Соп		5	leacher	Pu	blic Schools
and	I be fill hall Hed oth	Be	17. Father's Name (First, Middle, Last		18. Mother's Na	ame (First, Middle Maid	en Sumame)
Maryland	s 1 and 2 should be filed within 72 hr I Health and Mental Hygiene. Item 27 Is marked other than "naturither traumatic event, the Mazical	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or F	Rural Route Number, Cit	v or Town, State, Zip Code)
	aith ar 27 Is or trau		Alfred Barnes	Jr. /80N 56	05 Wesley Ave.	Baltimor	e, MD 21207
Baltimore,	00-		20a. Method of Disposition 1	20b. Place of D	isposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State
ij	Pages tment of tant: If it		4 □ Donation 5 □ Other (Specia	Garri		15/05	lurings Nills, MD
Bal	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service Lite	00 M 0	22. Write and Aldress of Facilities	cone Fune	ral Services
			23a. Part1. Eter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not	enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· MULTIPL	E MYELOMA		Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequence of)			
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of)			
>	nd ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	•			
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8760,	cate be executed physician and the burial-transit	dicai	•	d			
9		/Me	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery
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	wrequires that the death certifibeen signed by the attending should be detached for use as	by	Part II. Other significant conditions	ontributing to death but not resulting in the	ne underlying cause given in Part I.		o use contribute to the cause of death?
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Rec	e las has je 2	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ta	sician: Th certificate rector, pag	Be Co	25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 ☐ 1 eath (Check only one)	√o 1 ☐ Yes 2 ☐ No
Ξ	ysicia is cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	04	Home 5 Residence	6 □Other (Specify)
Division of Vital Records,	ng Ph Ifter th Ineral		27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injury at	28d. Describe how in	
isio	ttendi death. :tor: A	icati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b		M 1 Yes 2 No	206 1 1 (61 4	and Number of Devices
Div	after a Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospital or Attending Physician: To thin 24 hours after death. To thin Funeral Director; After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Pt	ysicien: To the best of my knowledge, or	leath occurred at the time, date and place	e, and due to the cause	(s) and manner as stated.
	the H nin 24 the Fi	Medical	one)	niner: On the basis of examination and/o and manner stated.	or investigation, in my opinion, death occ	curred at the time, date a	nd place, and due to the cause(s)
	or with con	~	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
7	7		30 Name and address of person who	completed cause of death (Item 23a) (Ty	D0059107	- 0.00	7-11-2005 1EIGHTS AVENUE
	2				CAL ERVUP BAL	TIMBES	MO 21215
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	de)	1111-1-1	11.4%

	. 1	For State Registrar	Otato or i	-		rtment of H tificate of L		i i u i vi	Omar m	Reg. N		p==	0017
Dhusisia		1. Decedent's Name (First, Middle, L	•						2. Date of I	Death Da	2 U U	ear	(3. Time of Deal
Physician /Medica		ERNEST BURTON,	JR.						JWCLY	12		205	1046 A
Examine	r '	ta. Facility Name (If not institution, g SiNA1 HOS? (TAL		er) Timone		4b. City, Town, or			city	4	c. County of N		
Funeral		5. Social Security Number 6.		Age (In yrs. last bin		If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. Min.	8. Date of E	Birth Day, Year	9.	Birthp	lace (State or For
Director		213-40-3511	1∏M 2□F	61	Yrs.	July 5	1100.0			7-19			YLAND
*	-	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loc	ation						1	Od. Inside City Lin
28a-f show	0	MD. BALTIMO	RE	RANDA	LLS	TOWN							tyt Yes 2 □
28a	- ec	10e. Street and Number				10f. Zip Code				10g. C	itizen of Wha	it Cour	itry?
30.00	Funeral Director	3928 McDONOGH	חם			2113	13				USA		
ams 2	Der	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	spanic Orig	in? (Spe	cify Yes or I	No-	14. Race -		
a la	2	1 Never Married 2 Married				Yes 2 No	Specify:	Puelto I	rican, etc.)		Black, '		
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f Health and Mental Hygiene. item 27 Is marked other then "natun other traumatic event, the Medical	Completed	15. Decedent's (Specify only highest of	Education trade completed)	16a.	(Give k	ent's Usual Occupa rind of work done of O NOT use retired	lurina most :	of worki	ng	16b. l	Kind of Busin	ess/In	dustry
than	E	Elementary/Secondary (0-12)	College (1-4	or 5+)		INEMAN	,				FACTO	RY	
h and Mentat Hygiene. 7 Is marked other then ", traumatic event, the Mad	3	17. Father's Name (First, Middle, La					18. Mother	's Name	(First, Mida	lle, Maide	n Sumame)		
c eve	ŭ	ERNEST BURTON.	•						HARRI		,		
marija M	0	19a. Informant's Name/Relationship		19b.	. Mailing	Address (Street a					or Town, Sta	te. Zip	Code)
ulth au 27 Is r trau		FRANCES CARTER	(SISTER)			HURCH ST.				-			
of Health item 27 I r other tre	-	20a. Method of Disposition		20b. Place of	Dispos	ition (Name of atory or other place			ate		ocation - Cit		
nt: f		1 Burial 2 Cremation 3 1 Donation 5 Other (Special Control of the Control of th	☐Removal from Sta cify)			CEMETERY	ິ ¦ 7	-15-	-2005	BAL	TIMORE	, M	ARYLAND
Department of the Important: If ite any injury or of once.	1	21. Signature of Fundamental Service Lig	HTANOL Gerne	KN D. HIB	NE R	Name and Address	s of Facility	PHII	LLIPS	FUNE:	RAL HO	ME,	P.A.
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ysician Medical raminer	ATT AND ADDRESS OF THE PARTY OF	shock, if heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ASP	as a consequence		Pu€ V	uon;	4					Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (clisease or injury that initiated events	b. Due to (or	as a consequence	of):								
	dicai Exa	resulting in death) Last	Due to (or	as a consequence	of):								
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ed by the attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		n 2 Fetal death It at time of death		Ectopic pregnancy Other (specify)				-	23d. Date o Month	f delive	ny Day Year
igned by	<u>a</u>	Part II. Other significent conditions	contributing to deal	th but not resulting in	the un	derlying cause give	en in Part I.		23e. Di	d tobacco	use contribu	ite to th	e cause of death
ld be	d by	cenero un w/A	N MSE	THE A	WE	m12.			1[Yes :	2 □ No 3 [] Prob	ably 4 Donkn
as been si	Completed	Divertioner	disEAS	e '		/			24a. W	topsy	24b. Wei	e auto	psy findings avail
page 2	Col								pe 1 ☐ Yes	rformed?	dea	th?	2 No
# 10	Be (25. Was case referred to medical examiner?						of Death	(Check onl	у опе)			
sid in	0	1 ☐ Yes 2 ☑ No	Hospital: 1 Inp				4 🗀 1401	-			6 □Other (Specif	/)
fter	ation:	27. Manner of Death 1 ▼Natural 5 □ Pending 2 □ Accident investigat		Injury 28b. 1 Day Year)	Time of njury	28c. Injury Work	vat ∢? Yes 2 □ N		28d. Describ	e how inj	ury occurred		
within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not determine	289. Place of	Injury - At home, fa , etc. <i>(Specify)</i>	ırm, stre	eet, factory, office		;	28f. Location City or T	(Street a Town, Sta	and Number (te)	or Rura	l Route Number,
n 24 hou he Funel pletely fill	Medicai	29a. Certifier 1 Certifying (Check only one)	Physicien: To the beeminer: On the bas and manne	is of examination an	e, death d/or inv	occurred at the timestigation, in my of	ne, date and pinion, death	l place, a h occurr	and due to the ed at the tim	ne cause(e, date ar	s) and mann nd place, and	er as st	ated. the cause(s)
withir To the comp	Ž	29b. Signature and title of certifier	MD			29c. License		000)	29d. D	ate signed (A	Month.	Day, Year)
1		30. Mange and address of person when the state of the sta	o completed cause	of death (Item 23a)	(Type, F	REPOSPITA	4	OZ	BA	2-7	MAGA	=	
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			. For	State of Marylan	d / Depart	ment of H	lealth and I	Mental Hygi	ene					
			State Registrar		Certif	ficate of	Death		g. No. 2005					
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give	. Caldu	Jell 41	b. City, Town, o	r Location of Death	2. Date of Death Month	Day Year Y 13, 200 4c. County of Dea					
1	LXaiiiii	ici	Saint Joseph		nter		Tow	son		ltimore				
	Funeral Director		5. Social Security Number 6. Sep 235 - 44 - 1122 11	7. Age (In yrs.		f Under 1 Year fonths Days	If Under 24 Hrs. Hours Min.	(Month, Day, 1	9. Bir Co 3.3 (L).	thplace (State or Foreign buntry)				
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-1 show to Medical Executer round be notified at	ector	10a. State 10b. County BALDIN	10c. Cit	y, Town or Locati	hervil	le			10d. Inside City Limits				
	with the or 2	i D	10e. Street and Number	Ct		10f. Zip Code	1002	100	g. Citizen of What Co	ountry?				
	death ms 2%	nera	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. Was	s Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Race - Ame					
21215-0036	ours after urel', or Ite	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:	ł	Yes 2 No	Specify:	o Hican, etc.)	Specify:	hite				
15-	"nett	lete	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give kind	t's Usual Occup d of work done o NOT use retired	during most of wor	king	6b. Kind of Business	/Industry				
	filed within Hygiene. other then ent, it e M	е Сотр	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	News	spape	R	ne (First, Middle, Ma	1 (cula:	tion MgR.				
lan/	should be tind Mental I	To Be	Julius K. C	oldwell S	SR.		VERON	h Fi	Bailea					
, Maryland	01 10 == 0	•	19a. Informant's Name/Relationship (Ty	lusell	84131	Macau	and Number or Ru	Luthe	City or Town, State.	D 21093				
Baltimore,	permit. Pages 1 and. Department of Health Importent: If item 27 eny injury or other tr once.		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ F		Place of Disposition	on (Name of ory or other place	(e)	Date 20	Oc. Location - City or	Town, State				
III.	nit. Pa bartmen ortent; injury e.		4 □ Donation 5 □ Other (Specify)21. Signature)of Funeral Service Licens	Do	laneyVal	ame and Address	Gard 17-		limonion					
Ba	permit. Departr Importe eny inj		21. Signature of Pulleran Service Licens	La Va Anti	PCIA	^		OPKRD.	TIMOLIU	MM MD 2109				
			23a. Part I. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the deat	h. Do not enter th	he mode of dyin				Approximate Interval Between				
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, P.O	that the hold by detail		Part II. Other significant conditions cor	ntributing to death but not res	23e. Did toba	23e. Did tobacco use contribute to the cause of								
rds	quires an sign uld be	ed b						1 ☐ Yes	2 □ No 3 □ Pr	robably 4 Unknown				
Records,	sicien: The law requir s certificate has been si irector, page 2 should	Completed by						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of				
Vital	cien: ertifica	Be	25. Was case referred to medical examiner?					th (Check only one)	1	-/>				
€	this ald	1º	TO THE ZEINO	lospital: 1 ☐ Inpatient 2		3 DOA Oth	4 Nursing H		ce 6 □Other (Spe	cify)				
- Lo	ding I h. After funer	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of 28c. Injury at Work? 1			28d. Describe how injury occurred						
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	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical C												
	To the To the Comp	M	29b. Signature and title of certifier			29c. Licens	e number		d. Date signed (Mont					
	1 15			0)2	~	D a	25686		7-14-05					
,	5%		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type, Prin	nt)								
			EBRAHIM IDAKCI 31. Date filed (Month, Day, Year)	I M D 7617		DRIVE	TOWSOI	MARYLA	ND 21204					
	Sta Registi		31. Date filed (Month, Day, Year)	5 Kener L	K Soes	No.								

		1 - For State Registrar		Maryland / D	•	ent of H ate of I			Re	eg. No2 0 (15	23179	
Physi		 Decedent's Name (First, Middle, Last TRISTAN KAJ CHIRIKADZ 							2. Date of Deat Month July 2,	h Day 2005	Year	3. Time of Death	
/Med Exam		4a. Facility Name (If not institution, give HOLY CROSS HOSPITAL	street and numbe	street and number)		4b. City, Town, or Location of Death			4c. Count		y of Death		
Funera Directo		N/A	x 7. / CMM 2□ F	7. Age (In yrs. last birthday) Yrs.		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Birth (Month, Day, JUNE 27,	Year) 2005	Year) 9. Birthplace (St Country) MARY LAND		
5-0036 72 hours after death with the Maryland returns!, or iteme 23e or 28e-f show digal Examinat he motified at	Director	Usual Residence of Decedent 10a. State 10b. County MD MONT GOME 10e. Street and Number	ERY	10c. City, Town	VILLE	Zip Code				0g. Citizen of W		10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
eath with the 23a or 3 must be a		14543 ALMANAC DRIVE 20866						USA		can Indian,			
15-0036 772 hours after death with the Maryla "natural", or iteme 23a or 28a-1 ehov edical Ezaminar must be motified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Dates	s?]No	If Yes,	specify Cuba	Specify:	, Puerto	Rican, etc.)		k, White,		
T C 1. 34	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	College (1-4or 5+) (Give life. L		Decedent's L Give kind of life. DO NO LNFANT	dent's Usual Occupation kind of work done during most of working DO NOT use retired) ANT			ing	16b. Kind of Busines		ss/Industry	
re, Maryland 212 s 1 and 2 should be filed withi f Health and Mentel Hyglene. Item 27 te marked other then other treumatic event, the	To Be C	17. Father's Name (First, Middle, Last) TARISAI KEN CHIRIKADZ					TH	IELMA	(First, Middle, M	IR			
the Hand		19a. Informant's Name/Relationship (7 THELMA KNUTSDOTTIR / 20a. Method of Disposition		20b. Place of E	4543 AL	MANAC D	RIVE,	BURTO	NSVILLE, I		20866	5	
Baltimore, parmit. Pagas 1 ar Dapartmant of Haa important: If them		1 Burial 2XX Cremation 3 \(\) 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen)	BALT/WAS	H CREMA	or other place TORY and Addres			ECK FUNER	LAUREL, M AL HOME,		ND	
n goes		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caus	ed the death. Do no					LAUREL, I		20707	Approximate Interval Between	
Pnysiciai /Medica Examine		Immediate Cause (Final disease or condition resulting in death)	RESPIRATORY FAILURE 2 HOURS Due to (or as a consequence of):								Onset and Death 2 HOURS		
	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	Due to (or as a consequence of):						4 DAYS			
HECORDS, P.O. BOX 68/6U, P. The law raquiras that the death certificate be axaculed at hes been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 □Ectopii 5 □ Other	c pregnancy (specify)				23d. Date Mon		ery Day Year	
COLDS, P. wraquiras that bean signad by should ba data	ed by Pr	Part II. Other significant conditions or	ontributing to death	tributing to death but not resulting in the underlying cause given in Part I.				Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
	Completed by							24a. Was an autopsy fir prior to completic death? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ N		mpletion of cause of			
of Vital F Physician: Th this cartificata ral director, pag	B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								141		
VISION OF Attending Physic death. ector: After this by the funeral di	atlon; To	27. Manner of Death 1 🕅 Natural 5 🗆 Pending 2 🗀 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No					28d. Describe how injury occurred					
DIVISION To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completally filled in by the funer	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specify) 286. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify) City or Town, State)										
DIV To the Hospital or A within 24 hours after To the Funeral Dire complataly filled in by	Medical	29a. Certifier (Check only one) 29a Certifier (Check only one) 29a Certifier (Check only one) 29a Certifier (Check only one) 29a Certifier (Check only one) 29a Certifier (Check only one) 29a Certifier (Check only one) 29a Certifier (Check only one)								tated. the cause(s)			
Tot Tot com	Σ	29b. Signature and title of certifier	al.			29c. License	number	-50	25	d. Date signed		Day, Year)	
5		30. Name and address of person who o	completed cause of	f death (Item 23a) (T	ype, Print)	שט) <u>5</u> 55	000		7-1-20	05		
	tate	JEWEL HIND, M.D. 31. Date filed (Month, Day, Year) JUL 1 5 2		strar's Signature	1	<i>.</i>							

			1- State of Marylan	•	artment of Hertificate of L		-	iene	0 ==		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Lula Belle Cadden			-	2. Date of Death July 12	2, Day 2005	Year	32 ing of pool 0 5:00 am	
	Examin	ner	4a. Facility Name (If not institution, give street and number) 1861F Edgewater Drive	4b. City, Town, or Location of Death Edgewood			4c. County of Death Harford				
	Funeral Director		5. Social Security Number 447-22-7268 6. Sex 1 ☐ M 2√ F 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)923	9. Birthpla Kenti	ace (State or Foreign try) ucky	
21215-0036	death with the Maryland rns 23a or 28a-f show	Completed by Funeral Director		y, Town or Lo Edgewoo			10	og. Citizen of W		0d. Inside City Limits 1 □ Yes 2√□ No try?	
	hours after death with tural, or itams 23a or al Expuller mant be		1861F Edgewater Drive 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ₺ Divorced 1861F Edgewater Drive 12. Was Decedent Ever in U Amged Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1 1	21040 Was Decedent of His f Yes, specify Cubar	spanic Origin? (Specify Yes or No-	U.S.A	- America , White, e	an Indian,	
	be filed within 72 hours after death with the Marylan Ital Hygisne. Id othar than "natural", or itame 23a or 28a-1 show evant, itte Medical Extensiver man be notified at		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years 17. Father's Name (First, Middle, Last)	16a. Deced (Give life. I		uring most of wo	orking	16b. Kind of Business/Industry OWn home			
yland	should be find Mental H marked off	To Be	Edward Carter				me (First, Middle, M Harper	faiden Sumame)		
re, Ma	and 2 ealth a m 27 is her trau		19a. Informant's Name/Relationship (Type, Print) Bridget Cadden/daughter	1 St.			oingdon, M	D 21009)		
	permit. Pages 1 Department of H Important: If ite any injury or ott		1 ₺ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	rford N	lem. Gdns.	7/15	5/2005 A	berdeer	, Md		
pa	permit Depsr impor any in		21. Signature of Sur Frail 1994 Udensee		10 W. Mad	Phail F	Home of	Air, Mc			
	Physician /Medical Examiner	ation: To Be Completed by Physician/Medical Examiner	23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failured List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Cause of the Cource of t								
ב ו	cate be executed physician and the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o. Injury that initiated events resulting in death) Last b. Due to (or as a conseq o. Due to (or as a								
	es that the death certific igned by the attending p be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of december of the pregnant at time of the pregnant at time of december of the pregnant at time of december of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery	y Day Year	
	w requires that been signed I should be det		Part II. Other significant conditions contributing to death but not res Alabetes Mellitus	as contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3 P						e cause of death?	
							24a. Was an autopsy perform 1 Yes 2	pr led? de	ere autops for to comp ath? Yes 2	sy findings available interest of 2 No	
	ing Phy h. After this funeral d		25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 27. Manner of Death 1 Accident investigation 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	e of 28c. Injury at 28d. Describe how injury occurred						
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	To the Hospital or At within 24 hours after d To the Funaral Diract completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To t To t	M	29b. Signature and title of certifier	mo	29c. License			d. Date signed		ay, Year)	
	5				opkins Bu	yview C	40 ircle Ba	ltimor	MI) 21274	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 5 2005	ture /	buti		•				

			For Stata Registrar	State of Ma		artment of F ertificate of		-	giene Reg. No. 2	105 23101
	Physicia /Medic	an al	Decedent's Name (First, Middle, La	Myrtle E	Clsie Co	rnish		2. Date of Dea Month 7	Day 11 200	
	Examin	er	4a. Facility Name (If not institution, giv				r Location of Deat	h	4c. County	
	Funeral		5. Social Security Number 6. 5		(In yrs. last birthday	Balto If Under 1 Year	If Under 24 Hrs		N/A	Birthplace (State or Foreign Country)
	Director	L	210-12-3130	і	84 Yrs.	Months Days	Hours Min.	12-30	0-1920	Md Md
200		-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation.				10d. Inside City Limits
Many	f sho	ţō	Md Balto		Glen Bu	rnie				1 ☐ Yes 2X No
4	or 28a	irec	10e. Street and Number	1.		10f. Zip Code			10g. Citizen of V	/hat Country?
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1215-0036	perfilt. Tages I affect should be free while 75 floors after beautiful and the way real perfilt. Tages I talk a Morald Hygione. Important: If itam 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it is Modified at 2000.	by Funeral Director	11. Marital Status You Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Every Armed Forces? 1 Yes 2 And If Yes, Give Year or Dates:	ver in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No		pecify Yes or No- to Rican, etc.)	- 14. Race Blac Specify	e - American Indian, k, White, etc. : Black
21215-0036	natura	Completed	15. Decedent's E (Specify only highest gr		16a. Dec	edent's Usual Occup	ation during most of wo	rkina	16b. Kind of Bu	
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d 2	Hygie thar t	ပ္	12th grade 17. Father's Name (First, Middle, Las.		N/A Nui	sing Assi		ne (First, Middle,	Maiden Sumam	9)
<u>a</u>	kad o	To Be	William Cornish				Mary A.	Hall		,
Maryland	s mar s mar	-	19a. Informant's Name/Relationship	Type, Print)	19b. Mai	ling Address (Street	and Number or Ri	ıral Route Numbe	er, City or Town,	State, Zip Code)
Σ,	ealth m 27 i		Beverly Holman	- Daughter	21	1 Scott A	venue G1			
Baltimore,	or oth		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 [ematory or other pla		Date		City or Town, State
Itim	it. ra irtmen irtant: njury	ŕ	*4 □ Donation 5 □ Other (Special Signature of Juneral Service Lice			Memorial 22. Name and Addre	1	8-2005 March F/	Arbutu:	
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م	nysician	. 10	Immediate Cause (Final disease or condition	Δ	sclaratio	cochie	ادادماد	diene		Onset and Death
	/Medical examiner		resulting in death)		consequence of):	CH CIN		41.266		Character !
	Zammer	<u></u>	Sequentially list conditions,		consequence of):	rend d.	secre			Unknown
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9 ×	attending pt	Physician/Med	IF FEMALE:	23c. If yes, outcome o	f pregnancy				11	
Вох	e attending p	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at t	! ☐ Fetal death 3	☐Ectopic pregnanc	у		23d. Dat Mor	e of delivery nth Day Year
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	gr es	by	Part II. Dther significant conditions	contributing to death but	t not resulting in the	underlying cause gr	ven in Part I.			ibute to the cause of death? 3 Probably 4 Onknown
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Rec	has has	т						autor perfo	osy prmed) d	rior to completion of cause of leath?
ta	certificate rector, pag	e C	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only o		☐Yes 2☐No
	dii d	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	t 2 ER/Outpati	ent 3 DOA Ott	ner /	lome 5 ☐ Resid		er (Specify)
	aing rin h. After th funeral		27. Mannor of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wo		28d. Describe I	how injury occurr	ed
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5	after deat Diractor:	ertif	4 Homicide determine	building, etc.		treet, factory, diffice		City or Tox		or or naral nodio rumber,
	to the Hospital of within 24 hours after To the Funeral Directory completely filled in Directory	edical C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exe	hysician: To the best of miner: On the basis of and manner stat	examination and/or	ath occurred at the ti investigation, in my	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
İ	withii To the	M	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed	(Month, Day, Year)
•			1)5	2 M	0	Dox	27050		7/12/0	70
	M		30. Name and address of person who	1: MO	16	00 1	. h		R	N. AAO
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regigna	r's Signature	00 hes	7 m7	Luged F	JUL D	414 MO 21217
** F	Regist		JUL 1	5 2005	r's Signature	Goste				

			1 = For State Registrar	State of Maryla		artment of H rtificate of			Re	g. No.	20	05 2310	2
	Physici	an	1. Decedent's Name (First, Middle, Last					2.	Date of Deati Month	Day	Year	3. Time of Death	3
	/Medic		Lawrence C	cornell		4b. City, Town, o	or Location of C	Death	JUI		County of Dea	05 11:45F	_
	Examin	er	Saint Joseph		enter	40. Ony, 10mm, 0		0 W S 0	n	10. 0		ltimore	
	Funeral		Social Security Number 6. Se		s. last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8.	Date of Birth (Month, Day,	Year	9. Bi	rthplace (State or Foreign ountry)	_
	Director		220-18-8515]M 2□F	78 Yrs.	Months Days	Hours		c.11.			ryland	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation						10d. Inside City Limits	-
	Mary Sho	호	MD Balti	more	БiМ	dle Riv	er					1 ☐ Yes 24 ☐ No	
	or 28a	lec	10e. Street and Number			10f. Zip Code	<u></u>		10	Og. Citize	en of What C	ountry?	_
	23a (Funeral Director	417 Tidewater	Lane		2122	0			USA			
_	tems tems	ne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H f Yes, specify Cub	lispanic Origin an, Mexican, F	n? (Specif Puerto Ric	y Yes or No- an, etc.)	14	4. Race - Am Black, Whi	erican Indian, te, etc.	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:	i	1 ☐ Yes 🎉 No	Specify:			5	Specify: Wh	nite	
Š,	72 hours aller death with the Maryland natural', or Items 23a or 28a-1 show dical Examinat must be notified al	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occur	pation	4 - 11-		16b. Kind	d of Business	VIndustry	_
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and	ntal H ed off	Be	17. Father's Name (First, Middle, Last) Emil Cornell						irst, Middle, M Baffc		iumame)		
Maryland 21215-0036	Should od Me mark matik	ဥ	19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Maili	ng Address (Street	-				Town, State,	Zip Code)	_
Ž	alth a 27 is or trat		Geraldine Corne	ell /wife	417	Tidewat	ter La	ne I	Balto.	MD	21220)	
ore,	ot He ot He fitem rothe		20a. Method of Disposition 1 ➡Burial 2 ☐ Cremation 3 ☐ F	Domarral from Chata	cemetery, crei	sition (Name of matory or other pla		Date			ation - City or		
<u>Ĕ</u>	Pag ment lant: I		*4 Donation 5 □ Other (Specify)	30	4 4	eartofJe		7/14,	/05	Ba	ltimo	ore MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Innorrant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, I'm Medical Examinat must be notified all once.		21. Signature of Funeral Service Licens	Connel	22	Name and Address 300 Mac						meofEssex	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ications that caused the de ne cause on each line.	ath. Do not ent	er the mode of dyir	ng, such as ca	rdiac or re	espiratory arre	est,	MD ZT	221 Approximate Interval Between Onset and Death	
	hysician		Immediate Cause (Final disease or condition resulting in death)	SEPTIC S	SHOCK .							DAYS	
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Вох	death s atter d tor u	Iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)	У			20	Month	Day Year	
		hys	9 Unknown	9□ Unknown									_
S.	o o o	þ	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause giv	ven in Part I.					o the cause of death?	
oro	w requir been si should	eted						-	1 □ Ye	_ /		robably 4 Unknown	
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<u> </u>	Physician: r this certitio ral director,	ToB	eyaminer?	Hospital: 1 Inpatient 2	☐ ER/Outpatier	at 3 DOA Oth	200	•	theck only one 5 ☐ Reside		□Other (Spe	ecify)	-
و ر ا	ng Phy ter thi neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o				I. Describe ho			,/	-
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) A. U. H	alou, M.	() .	D	17695		J	illi	1 11,	,2005	
	8		30. Name and address of person who co	ompleted cause of death (It	em 23a) (Type,								
	V		ARDALLAH J. HI	Begistrar's Sig	76.01 O	SLER DR	IVE TO	JWSO	N MAR	YLAN	4D 21	2014	-
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:15 PM Robert Leon Cutsail, Sr. July 11 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kline Hospice House Frederick Mt. Airy If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 215-44-9536 60 Yrs. December 24, 1944 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Madical Examinar must be notified at Director 1 Yes 2 □ No Maryland Frederick Brunswick 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? or Items 23a or 520 West "C" Street 21716 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: White þ 3 Widowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Brick Mason Construction other t permit. Pages 1 end 2 should be file Deportment of Health and Mental Hy Important: If Item 27 is marked oth-any Injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Sylvester Cutsail, Sr. Mabel Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 West "C" Street, Brunswick, Maryland, 21716 Barbara R. Cutsail/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery July 16, 2005 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 106 East Church Street 5 Milliano Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure 7 days /Medical Due to (or as a consequence of): **Examiner** Multiple Lung Metastasis 4 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner be executed burial-translt Rectal Cancer 7 years Due to (or as a consequence of) Box 68760 Physician/Medical the USB BS 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) ed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records. 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No 2 X No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🗀 Inpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) (\) Other (Specify) Hospice House 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. I Director: After After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospitel within 24 hours a To the Funeral E Hospitel 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D146 2C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St 501 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			Registrar 1. Decedent's Name (First, Middle, Last)			itinicate or	Death	2. Date of Death		2 Time of Dah
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3	filed within 72 hours after death with the Maryland Hygiene. Hygiene natural; or items 23s or 28s-f show ant, it s he also Examiner must be notified at		15. Decedent's Educa		rean	dent's Usual Occup	ation	16	6b. Kind of Business	White
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Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type	, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Number, (City or Town, State, .	Zip Code)
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	11-		30. Name and address of person who com	pteted cause of death (I	tem 23a) (Type,	Print)	סטכניית		July	13, 2005
10	1 9		Victor M. Priego, M	D. 6420 Ro	ckledge	Drive #4	100 Beth	nesda, Mar	yland 208	1.7
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			_ For	State of Marylan	d / Departme	ent of Health and	d Mental Hygie	ne	
			State Registrar		Certifica	ate of Death	Reg.	No. 2005	00105
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but s			5. Social Security Number 6.5	RD .RANDA-LISTO ex 7. Age (In yrs.	7 -	NDALLSTO CUN, der 1 Year If Under 24 h		BALTIMO	
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	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show the Medical Examinar musi Les mollinal at	by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 2 No	.S. 13. Was De ff Yes, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Americ Black, White,	
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28e-1 show amply injury or other traumatic event, the Medical Examinat must be notified at Once.		19 . Informant's Name/Relationship	7	19b. Mailing Addr	ess Street and Number of	11		Code)
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별	permit. Page Department i Important: If any injury or once.		21. Signature of Funeral Service Lice		ing Parl	and Address of Fability	119/05 K	Samo	11000
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	To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier	hysician: To the best of my kno	owfedge, death occurr	ed at the lime, date and pl	ace, and due to the caus	e(s) and manner as st	ated.
	n 24 he Fu	edical	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	ation and/or investigat	ion, in my opinion, death o	ccurred at the time, date	and place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	100		29c. License number	29d.	Date signed (Month,	Day, Year)
7			· anilma Li	he mo		10024710	্ ্	177 15	2005
			30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	0 0024 9 70 RDAO, RA	000110	il maa	2/133
		124	CL) ff (1810 FRBER) 31. Date filed (Month, Day, Year)	32. Registrar's Signa	LIJ LVV6C)	ICAO, KME	1001225717	1 / 1 / 1 / 1 / C	YLAND
	St: Regist	ate	1111 1 E 2005	32. Hegistral's Signi	houst .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Gloria Camphor 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Baltimore Washington Medical lenter endurnie 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Maryland Director 218-42-6321 Oct 26, 1939 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or itams 23e or 28e-f show any injury or other traumatic event, If a Marical Examination with be redifficial at once. 1 XYes 2 □ No Glen Burnie Director Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Evans Street 21060 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo Baltimore, Maryland 21215-0036 Specify. Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Private Homes** Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 212 Evans Street Glen Burnie, Md. 21060 Carmen Edwards Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/13/05 Catonsville, Md. * 4 ☐ Donation 5 ☐ Other (Specify) Cremation Society (Metro 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service PA 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weeks neumon /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 No 1 Yes 1 ☐ Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 4 Nursing Home Yes 2 🗆 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) Certification 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ocertifier Allend 29d. Date signed (Month, Day, Year) 29b. Signature and title 2005 July 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 He mit all S. SAWHNEY Bus GURMEET 32. Pigistrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** Dorothy Elizabeth July 2005 18:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ± 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F Director 64 217-36-2882 11. 1940 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 22 Brooks Road 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hyglene. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Mimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No þ 37 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Edward Roberts, Sr. Margaret Jean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3100 Whitefield Road, Churchville, Maryland 21028 Jean E. Mercado - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tment of 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ≒ ö Department of Important: If any injury or once. Bel Air Mem. Gardens 7/14/05 Bel Air, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. Marle T-50 W. Broadway Street, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Physiclan/Medical ast ed by the attending I IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No į Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 2 1 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an this certificate has page 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ M6 2 1 la atient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of ath (Item 23a) (Type, Print) ee Mame Manulax 31. Date filed (Month, Day, Year) State JUL 1 5 2005 Registrar

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D.	/Medic Examin		4a. Facility Name (If not institution, give Saint Joseph	street and numbe Medical	Cen	ter	4b. City, T	own, or Lo		Death W S O 1	n	4c.	County of D	eath 1 t i more
	Funeral Director		220 07 0001	ex 7. A □ M 2½□ F	nge (In yrs. 83	last birthday) Yrs.	If Under 1 Months		f Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da Sept.	th ly, Year) 16,1	9.1	Birthplace (State or Foreign Country) Maryland
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36	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or itema 23a or 28a-f show avant, the Madral Examinat must be notified at	by Funeral Director	8029 Park Haven 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Road 12. Was Deceder Armed Forces 1 Yes 25 If Yes, Give Year or Dates	s? ∄No		Vas Decede f Yes, specif		212 panic Origi Mexican, Specify:		cify Yes or No lican, etc.))-	14. Race - A	d States merican Indian, /hite, etc.
21215-0036	within 72 hour ene. than "natural ire Wedical E	Completed t	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation		(Give	dent's Usual kind of work DO NOT use	done dur retired)	on ring most	of workin	g	16b. Kir	of Busine	
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Balti	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licen		-	22	. Name and Duda-	Address Ruck	of Facility Fune	ral	Home o	of Du	ndalk	-
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		1 - For State Registrar			Certifica	ate of De	eath		Reg. No	200=	20100
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/Medi		William P. Dot			45 0	ity, Town, or Lo			15, Da	2005 County of Death	8:15 A ^M
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Funeral			. Sex 7. A	ge (In yrs. last	Month		Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth av. Year)	9. Birth:	place (State or Foreign
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yland 10W		10a. State 10b. County		10c. City, To	own or Location						10d. Inside City Limits
Ba-f st	ctor	Maryland Baltimo	ore	Essex							1 ☐ Yes 2≹QXNo
parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or Items 23e or 28a-f show Importent: If item 27 is marked other then "natural; or Items 23e or 28a-f show yor injury or other traumatic event, It a Madical Examination of the control of t	Funeral Directo	10e. Street and Number		44.5		Zip Code				tizen of What Coul	ntry?
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thours after during ruyarden. The farm equities that began command to account of the farm equities that the farm equities that been signed by the attending physician and solve filled in by the funeral director, page 2 should be detached for use as the burial-transit of the farm of the funeral director.	ertification: To Be Completed by Physician/Medical Ex	show, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ASPIRA Due to (or a b. Due to (or a c. Due to (or a d. Due to	TION PN s a consequence s a co	Do not enter the management of	c pregnancy (specify) ag cause given in 260 DOA Other: 28c. Injury at Work? 1 Yes ctory, office	n Part I. 5. Place of Dea 4 Nursing H 5. 2 No	23e. Did 1 1 24a. Wa. auti per 1 1 Yes th (Check only ome 5 Res 28d. Describe 28f. Location City or To	tobacco Yes 2 s an ppsy ormed? 2 No one) idence how inju (Street ar wn, State	23d. Date of delive Month use contribute to to the No 3 Protection of No 1 Protection of No. 1 Protection of No. 1 Protection of Number or Running.	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Page 1975 Pag
or Attending Physicien: The law requires that the death certificate be executed the death. Italier death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director.	Certification: To Be Completed by Physician/Medical Ex	shook, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Infer) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending investiga 3 Suicide 6 Could no determine (Check only one)	ASPIRA Due to (or a b	TION PN s a consequence s a co	Do not enter the management of	c pregnancy (specify) ng cause given in 28c. Injury at Work? 1 1 Yes etory, office red at the time, tion, in my opinion	n Part I. 5. Place of Dea 4 Nursing H 5. 2 No	23e. Did 1 1 24a. Wa. auti per 1 1 Yes th (Check only ome 5 Res 28d. Describe 28f. Location City or To	tobacco Yes 2 s an ppsy ormed? 2 No one) idence how inju (Street ar wn, State	23d. Date of delive Month use contribute to to the Month of the Month	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Page 1975 Pag

DHMH 17 Rev 1/2001

G	77		State of Maryland / De State of Maryland / De	partment of Health and Ne G846 8-16-05 tas ertificate of Death	Mental Hygie	ne No. 2005 2010
	Physici	an	1. Decedent's Name (First, Middle, Last) Stanley Joseph Dorsey		2. Date of Death	2005 Year 2:10 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 7001 North Charles Street	4b. City, Town, or Location of Death TOWSON		4c. County of Death
2	Funeral Director	6)	5. Social Security Number 187–12–5126 12 M 2 F 83 13 Yrs	ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign
4)	ith the Maryland or 28a-f ehow e notitied at		10a. State 10b. County 10c. City, Town o	Location 11 Timbers		10d. Inside City Limits 1 ☐ Yes 2☐ No
	th with the 23s or 28s	Funeral Director	10e. Street and Number 17809 River Shore Drive	10f. Zip Code 20690	10g.	Citizen of What Country? U.S.A.
920	72 hours after death with the Maryland naturel', or items 23a or 28a-f ehow dical Exeminar must be notitled at	<u>م</u>	11. Marital Status 1 □ Never Married 1 □ Never Married 2 □ Married 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sign Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho ene. then "natur re Msdical I	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired) lice detective	king	. Kind of Business/Industry law enforcement
Maryland 2	uld be filed Mental Hygie rrked other rtic event. II	To Be Co	17. Father's Name (First, Middle, Last) John Dwojewski	18. Mother's Nam	ne (First, Middle, Maid La Kasian	
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or items 23a or 28a-i ehov any injury or other traumatic event. In Modical Examinar must be notified at once.		Stanley Ronald Dorsey/son 80 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	ailing Address (Street and Number or Ru 3 Hickory Ridge Dra sposition (Name of crematory or other place) sary Cemetery 7/13	ive. Bel A	ir, Md. 21015 Location - City or Town, State
Baltir	permit. F Departme Importar any injur		21. Signatur 1 Fyrant I Service Licensee 23a. Part 1. Epte the disease, or complications that caused the death. Do not	22. Name and Address of Facility Schimunek Funeral	Home of B	el Air, Inc.
8760,	Physician (Medical Examiner whysician and physician by pricing the	Ilcai Examiner	Immediate dause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Hypertensive Ath Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	erosclerotic Cardio	ovascular 1	Disease Onset and Death
P.O. Box 6	ires that the death certifice signed by the attending pt d be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
	w requires that t been signed by should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the Cellulitis; Demenita	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
al Reco	: The law requicate hes been ; page 2 should	Completed			24a. Was an autopsy performed	
Division of Vital Records,	Hospital or Attending Physician: The law requires that the death certifica 4 hours after death. Funeral Director: Atter this certificate hes been signed by the attending phietly filled in by the funeral director, page 2 should be detached for use as it.	Certification: To Be	27. Manner of Death 1 \(\) Natural \(5 \) Pending \(\)	tient 3 DOA Other: 4 Nursing H e of Position Work? M 1 Yes 2 No	28d. Describe how in 28f. Location (Street	t and Number or Rural Route Number.
Ō	To the Hospital or Attendwithin 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, decrease (Check only 25 Medical Examiner: On the basis of examination and/c			e(s) and manner as stated.
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	29c. License number OCME	29d.	Date signed (Month, Day, Year)
			30 Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print 111 Penn Street		e, Maryland 21201
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 5 2005 Registrar's Signature	arte		

State of Maryland / Department of Health and Mental Hygieng 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month DRONENBURG CLIFTON JUL 08 2005 0830 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) f Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**∑**M 2□F Months Days Hours 218-10-8730 Director 85 Sept.20, 1919 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location **ehow** 10d. Inside City Limits Item 27 is marked other then "neturel", or Items 23e or 28e-f ehov other treumstic event, the Medical Exercitiver must be notified at Director 1 ☐ Yes 2 🔀 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14431 Traville Garden Circle, #209B death 20850 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other then "neturel", or Ite 1 Never Married 2 Married 1 XYes 2□No World IfYes, Give Year or Dates: War TI Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ Specify: 3 Widowed 4 Divorced War II Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic County Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Clifton Dronenburg Katherine Elaine Ricketts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20850 Lydia A. Dronenburg/Wife 14431 Traville Garden Circle, #209B, Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of July 14. 20c. Location - City or Town, State Parklawn Memorial Park ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. ^¹ 4 □ Donation 5 □ Other (Specify) 2005 Rockville, Maryland 21. Signature of Furieral Service Licensee M00803 Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** SIS DAY /Medical Due to (or as a consequence of) Examiner ADRTIC AN EURYIM NMOR Sequentially list conditions, if any leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ó 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) Month Day Year the 9□ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes _ 2 🖃 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 00057154 2017 10' 5002 e and address of person who completed cause of death (Item 23a) (Type, Print) SAFY JOHN MO 11125 ROCKULUE PIKE, ROCKULUE MO 20852 31. Date filed (Month, Day, Year) 32. ijwistrar's Signature State Registrar JUL 1 5 2005

		1- State of State of Registrar		partment of Health ertificate of Deal		al Hygien	7 / / /	23192
Physici		Decedent's Name (First, Middle, Last) Jula	ine D. Dill	on	M	ate of Death onth Da		3. Time of Death 9:58A M
/Medic Examin		4a. Facility Name (If not institution, give street and numb 19306 Frenchton Place	per)	4b. City, Town, or Location Montgomery	on of Death	40	County of Death	
Funeral Director		5. Social Security Number 6. Sex 1口 M 2 以 F 7.	. Age (In yrs. last birthda) 94 Yrs.		der 24 Hrs. A Da	ate of Birth	9 Birthr	place (State or Foreign
Maryland -1 show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery	10c. City, Town or I	ocation	e			10d. Inside City Limits 1∑Yes 2 □ No
th with the 23e or 28e	Funeral Director	10e. Street and Number 19306 Frenchton Place		10f. Zip Code 2088			itizen of What Cour	-
s after dear , or Items	by Funer	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give Year or Date	. ⊠No	. Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 🏻 No Spec		es or No- , etc.)	14. Race - Americ Black, White, Specify:	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Mimportent: If tien 27 is marked other then "neturel" or flems 23e or 28e-f show any injury or other treumatic event, if a Maryland Examinar must be notified an once.	Completed b	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	16a. Dec	edent's Usual Occupation e kind of work done during n DO NOT use retired)	nost of working	16b. F	Kind of Business/In	dustry
be filed wit tal Hygiene of other the event, tre	Be	17. Father's Name (First, Middle, Last) Alfonse de Thierry			other's Name (First	t, Middle, Maidei		e
d 2 should th and Mer 7 is marke treumatic	J.	19a. Informant's Name/Relationship (Type, Print) Robert A. Dillon, Jr./Son		ling Address (Street and Nur Box 363, Re		te Number, City	or Town, State, Zip	Code)
Pages 1 and 2 nent of Health a int: If item 27 is iry or other tre		20a. Method of Disposition 1 \(\mathbb{\text{\text{\$\text{\$B\$ Uritar}}} \) 3 \(\mathbb{\text{\$\}\$}}}\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\tex	20b, Place of Disc	position (Name of permatory or other place) Heaven	July 16	20c. L	ocation - City or To	own, State
permit. Departm Importe any inju		21. Signature of Funeral Service Licensee		obert A. Pump 557 Wisconsin	ncility		Rethes	da-Chevy
Physician /Medical		resulting in death)	used the death. Do not ench line. rtension r as a consequence of):	nter the mode of dying, such	as cardiac or resp	iratory arrest,		Approximate Interval Between Onset and Death
Examiner	ner	Sequentially list conditions b. Spin.	al Stenosis r as a consequence of):					
cate be executed physician and the burial-transit	dical Examiner	that initiated events c.	st Cancer					
The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as t	Physician/Med	in the past 12 months?	nt at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
quires that In signed by ald be deta	by	Part II. Other significant conditions contributing to dea	th but not resulting in the	underlying cause given in Pa	art I. 2	3e. Did tobacco	use contribute to the	he cause of death?
	Completed					4a. Was an autopsy performed? □ Yes 2 🖾 No	prior to co death?	psy findings available mpletion of cause of
To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	ilon; To Be	27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of (Month,	patient 2 ER/Outpatie	ent 3 DOA Other: 4	28d. D		6 ☐ Other (Specifury occurred	(y)
To the Hospitel or Attendi within 24 hours after death To the Funerel Director: 4 completely filled in by the fi	Sertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place o building	f Injury - At home, farm, s g, etc. <i>(Specify)</i>		28f. Lc	ocation (Street ality or Town, State	nd Number or Rura re)	al Route Number,
To the Hospitel or within 24 hours afte to the Funerel Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner of manner of the base and manner of the base and manner of the base and manner of the base and manner of the base of	is of examination and/or i	ath occurred at the time, date nvestigation, in my opinion, o	and place, and du death occurred at t	ie to the cause(s he time, date an	s) and manner as s id place, and due to	tated. the cause(s)
To t within	M	29b. Signature and title of certifier		29c. License numb			ate signed (Month, 11y 14, 20	
10			en Locks Roa		kville, M	laryland	20854	
Sta Registr		31. Date filed (Month, Day, Year) 32. Re JUL 1 5 2005	trar's Signature	Sperke				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** 14, July 7:40 Α Anna Marie Ehrhardt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 914 Fawn Court <u>Harford</u> Joppa If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 24, 1924 If Under Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months Hours 1 □ M 212 F Director 219-10-1575 80 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f shov the Medical Examiner count be notified at 1 ☐ Yes 2√2 No Maryland Harford Joppa Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21085 914 Fawn Court U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes ZNNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: White ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2€No Specify 3 Widowed 4 □ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Custodian School 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be intent of Health and Mental inter 27 is marked o Mary E. Dussman Charles N. Boykin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 914 Fawn Court, Joppa, Maryland 21085 Norman Ehrhardt (Son) other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Dependment Importent: If any injury or Holly Hill Mem. Gard. July 18, 2005 Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Sarves Live 12.9 22. Name and Address of Facility Ski Funeral Home, P.A. once 140/ Old Fastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a Part Ent he disease, or complications trat caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest leart failure. List only one cause in plach line. Immediat : ause (Final disease ir condition resultin : Leath) **Physician** /Medical (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit resten as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 Yes 2 2 No To the Hospitel or Attending Physicien: 25. Was case referred to dical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 🗌 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending 1 Yes 2 No investigation death ☐ Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 24 within 2 29d. Date signed (Month, Day, Year) License number 29b. Signature and title 29c who completed cause of death (Item 23a) (Type, Print 110/a BL 5°2005 State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY **Physician** 5:45 A. EVERETT, SR. WILLIAM WILSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HARFORD MARINER HEALTH OF FOREST HILL FOREST HILL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 JM 2 □ F 80 1925 Maryland 209-12-1270
Usual Residence of Decedent 4. Director 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Harford Fallston Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21047 USA 1310 Old Fallston Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 TY'es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or tien any injury or other traumatic event, Ite Marcal Examinations. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) US Government Maryland State Police 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel (UNK) Walker Chester Alvin Everett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1310 Old Fallston Road, Fallston, MD Helen Everett/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Bel Air Mem. Gardens 7-13-05 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses McComas Funeral Home, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 21014 Approximate Interval Between Onset and Death Immediate Cause (Final Partinonis Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Ninknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy 2 No 2 🗷 No 1 Tyes or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner's Other: AN Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes 2 No this stor: After this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours 2 To the Funerel 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Dav 3 032255 1002 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21014 615 W. MACPHAIL ROAD BEL AIR, MD. DR. DAVID DUNN _ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 5 2005 Registra

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** July 2005 5, 10:27 PMM Ella Exner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 23, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 💢 F Yrs. 83 1921 Director Maryland 217-12-9022 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28e-1 show eny injury or other traumatic event, the Medical Evantment in the standard of the contraction of the contractio 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 □ No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 520 S . Register Street 21231 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. unk 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anna Arendt Wilhelm Exner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 100 Hospital Road Prince Frederick, MD Calvert Memorial Hospital 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

Bonald S Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock to heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructive **Physician** hyonic /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Atrial Stenosis Completed Renal insubliciency 24b. Were autopsy findings available prior to completion of cause of death? Heart failure autopsy performed? 1 ☐ Yes 2 ☐ No Pneumonia infection. 1 Yes 2 1 No this certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tittle of certifier 50653 7-6-2005 cua 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN SURANA Deale 5851-Murchton Road. Deale 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 5 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 9:10 A_M Lawrence Carl Freeny Jr. 8 July 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 212 Aigburth Rd., Apt. 312 Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□F Months Days Hours Min. 86 Yrs. Director 220-10-8374 October 27,1918 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b County item 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, the Medical Evanturer must be notified at Maryland 1 ☐ Yes 2X No Baltimore Towson Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 212 Aigburth Rd., Apt. 312 United States Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1940–42 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours efter al Hygiene. I other then "naturel", or Ite 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) journalism writer 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be fi of Health and Mental H item 27 is marked of Alice Mabel Elderdice Lawrence Carl Freeny Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1022 St. Alban's Rd. Baltimore, MD Lauren L. Freeny/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem Gard Jul. 16,2005 Timonium, Maryland ¹ 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home Inc.
6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 day Physician a Pulmonary embolus /Medical Due to (or as a consequence of): Examiner 3 years Debillitation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 1□Yes 2XXNo Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\triangle \text{Nursing Home} \) 5 \(\text{X} \text{ Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 🛣 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 8, 2005 D55942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. Charles St. #203 Baltimore, MD 21204 Paul Foster 31. Date filed (Month, Day, Year) JUL 1 5 2005 Registrar's Signature State Registrar

CPM 05-4649 Clayton Fenner

Blease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar	State of Marylan		rtment of F tificate of			iene	
	3 1	Decedent's Name (First, Middle, Last)					2. Date of Deat	h 2005	3 Times of Delay 7
Physiciar /Medica	1	CLAYTON		FEN	NER		July	10°, 20°05	14:16 M
Examine	r	ta. Facility Name (If not institution, give s 2103 Homewood Avei			4b. City, Town, o Baltin	r Location of Death		4c. County of Death	A
Funeral Director	٤	x x 8 - 28 - 77 NO	M 2 F	19 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay,	Year) 9. Birthp 01,1926 NOR	ace (State or Foreign try) TH CAROLINA
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with the	Director	10e. Street and Number	EWOOD AV	PNUE	10f. Zip Code	1218	1	Og. Citizen of What Cour	try?
s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic avent, the Medical Examinar must be notified at	runeral	0.700	12. Was Decedent Ever in U. Armed Forces? 1	.S. 13. V	Vas Decedent of H Yes, specify Cubi	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- po Rican, etc.)	14. Race - Americ Black, White,	
Phours ature!, cal Exam	ed by	3 Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a. Deced	ent's Usual Occup	pation		16b. Kind of Business/Inc	ACK
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d be filed intal Hygid ed other	e Q	17. Father's Name (First, Middle, Last)		FFI	INFR	18. Mother's Nam	ne (First, Middle, I		DANIELS
and Mental is marked is umatic av	0	19a. Informant's Name/Relationship (Ty		19b. Mailin		(10000000000000000000000000000000000000	ral Route Number	, City or Town, State, Zip	Code)
00 = 5	1	DIANE FENNER 20a. Method of Disposition 1 Deurial 2 □ Cremation 3 □ R	(DAUGHTEL, 20b. F	lace of Dispo cemetery, crem	ARLI sition (Name of natory or other pla norial Pa		Date F	3ALTO, 1/2 20c. Location - City or To Woodlawn,	wn, State
permit. Pages 1 and Department of He important: If Itan any injury or oth gates.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		CONSTI	Name and Addre	CILI	OWN J.	R. FUNERA BALTO. MI	1. HOME 0.21217
Physician		23a, Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the deat ne cause on each line.					est,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Dura to (or as a conseq	quence of):			CT - VICE		
	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t						
	Medical	IF FEMALE:	d						
that the death certifice ed by the attending pr detached for use as It	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of conditions of the second	al death 3	Ectopic pregnanc Other (specify) _	у		23d. Date of delive Month	Day Year
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> 40 0	Complet						24a. Was a autops perfor 1 ☐ Yes	med? prior to co	psy findings available impletion of cause of 2 No
ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Ott	hor	ath (Check only or		
To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tlon: To	27. Manner of Death 1XXNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Inju	4 Nursing r		ence 6XOther (Specification ow injury occurred) SCENE
al or Attan safter deat I Director: d in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number or Rura n, State)	I Route Number,
Hospite 24 hours Funera	edical C	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the t vestigation, in my	ime, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner as s late and place, and due to	tated. o the cause(s)
To the within To the comple	Mec	29b. Signature and title of certifier	·	2000		se number)CME	- 2	July 12, 2	
NA		30. Name and address of person who co	ompleted cause of death (Itel	m 23a) (Type,	Print) 111 F	Penn Stre	et Balt	imore, Maryl	and 21201
Stat Registra		31. Date filed (Month, Day, Year)	32. egistrar's Sign	ature 6	andi)				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Robert Franklin State of Maryland / Department of Health and Mental Hygiene 05-04653 NJM Certificate of Death Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) July **Physician** ĬŎ 2005 1913 lliam /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City

9. Birthplace (State or Foreign <u> Johns Hopkins - Bayview</u> Baltimore
If Under 1 Year | If Under 24 Hrs. | Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace
 Country) **Funeral** Months Days Hours Min -19.3802 1 M 2□F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f ehow the Medical Exeminer must be notified at 1 Yes 2 □ No M Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21214 tai tora death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Bfack, White, etc. filed within 72 hours after Never Married 2 ☐ Married 5 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) Coflege (1-4or 5+) uden other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health, and Mental Hy Important: if Item 27 is marked oth any july or other traumatic event spre. 17. Father's Name (First, Middle, Last) Be tranklin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Franklin, Bristol 20c. Location - City or Town, State 12033 Smith 20b. Place of Disposition (Name of 20a. Method of Disposition

1 Burial 2 Cremation 3 F
4 Donation 5 Other (Specify) cemetery, crematory or other place. 3 Removal from State Minorial 22. Name and Address of Facility TIMORE, MD 21234. 21. Signature of Funeral Service WANS FUNERAL CHAPEL 8800 HARFORD RD 23a. Part. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) trole **Physician** Due to (or as a consequence of) wies /Medical Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 by Physician/Medicai 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown cate has been sig , page 2 should b Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of prior to co detail? 1 es 2□ No this certificate 1 Yes 2 🗆 No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Be Other: 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes To the Hospitel or Attending Phys within 24 hours after death.
To the Funerel Director: After this completely filled in by the funeral dir 28d. Describe how injury occurred 27. Manner of Death 5 | Pending investigation | Could not be determined | Pending investigation | Symmetry | Pending investigation | Could not be determined | 28e. Place of Injury - At home, farm, street, factory, office | 28f. Location (Street and Number or Rural Route Number, Street) | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City of Lown, Stafet | City o 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide Tarkw 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME July, 11, 2005 MO 30 Name and address of person who completed cause of death (ftem 23a) (Type, Print) Penn Street iUA Aco Pagistrar's Signature 31. Date filed (Month, Day, Year) 32. State JUL 1 5 2005 Registrar DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryla		rtment of H			giene Reg. No. O. O. O.	
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give st	reet and number)	Fla	etch 4b. City, Town, or	Location of D	2. Date of De		5 9 P W
	Funeral Director		5. Social Security Number 6. Sex 218-62-3895	Medical (7. Age (In y. 50	enter rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birt (Month, Da 08 15	y, Year)	Birthplace (State or Foreign Country) MD
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD NA		City, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No
	thin 72 hours after death with the Maryland e. an "natural", or Items 23e or 28e-f show Medical Ezaniran must be rollified at	Funeral Director		Was Decedent Ever in Armed Forces?	13. V		218 Ispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	10g. Citizen of What U • S • 14. Race - A Black, V	
21215-0036	in 72 hours aft "natural", or hedical Exami	Completed by F	1 Never Married 2 Married 3 Widowed 4 Nover Married 15. Decedent's Educ (Specify only highest grade	completed)	16a. Decec	lent's Usual Occup kind of work done of NOT use retired	during most of	working	Specify:	Black ess/Industry
	be filed wil ntal Hygien ad other th event, the	Be	12th Grade 17. Father's Name (First, Middle, Last) Marion G. Fletch	na	Rea	l Estat	18. Mother's	nt Name (First, Middle, abeth B.	Maiden Sumame)	Estate
e, Maryland	s 1 and 2 should I I Health and Menl Item 27 Is marker other treumatic	To	19a. Informant's Name/Relationship (Typ. Lynette Fletcher 20a. Method of Disposition	e, Print) -Sister		Reddic	and Number o	r Rural Route Numbe	er, City or Town, Stat	d 21163
Baltimore,	permit. Pages Department of I Important: If its any injury or or once.		1 Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State	rownsv	natory or other plac	t. 7/	/15/05		ille, Md
	Flysician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the decause on each line.	eath. Do not ent	300 Wab	ash As ig, such as car	ve, Balt: rdiac or respiratory an		d 21215 Approximate Interval Between Onset and Death
	/Medical Examiner	ıer	resulting in death) Sequentially list conditions, it any learn a bottom eather cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of): FAILURE					1 day
8760, 🕸	ate be executed hysician and the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	NECROTI		WEZ				(any
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)	/	100	23d. Date of Month	delivery Day Year
Records, P.	n requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not	_	nderfying cause giv	ren in Part I.	1	res 2.0 % 3	e to the cause of death?] Probably 4 □Unknown
Vital Rec		se Completed	25. Was case referred to medical				26. Place of	24a. Was autor perfo	osy prior deat 2 2 10 1 1	e autopsy findings available to completion of cause of h? Yes 2 No
of	ding Phys n. After this funeral di	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Impatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time of Injury	28c. Injur Wor	4 ∐ Nursii v at		dence 6 Other (S	Specify)
Division	5. 2. # Q	ai Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	ecify)knowledge, deatl	occurred at the tir	ne, date and p	City or Tou	vn, State) cause(s) and manne	r Rural Route Number, r as stated.
1	To the Hospital or within 24 hours after To the Funeral Director completely filled in It	Medical	(Check only 2 Medical Examinate) 29b. Signature and title of the rifter	er: On the basis of exam and manner stated.	nination and/or in	vestigation, in my o	ppinion, death of	occurred at the time,	date and place, and 29d. Date signed (M	due to the cause(s)
1/=	4+1			SE MD,	10 No			35 L 15873 REET B	ALTIMORE	MARYLAND 21201
	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 5 2	32. Registrar's Si	J. J.	carle		•		

			1 _ For	State of Maryland /	Department of Health and	Mental Hygie	ne	
			Registrar 1. Decedent's Name (First, Middle.	l act)	Certificate of Death	Reg.	No. 2005	3 dime of Realth
	Physici		James 1	Ellsworth	Frazier	Month 4	Day Year	451 PM
	/Medio Examin		4a Facility Name (If not institution,	gife street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death	
1			Baltimore 1	/A Medical Cen	ter Baltimor	e		
	Funeral Director		212 84 7/10	6. Sex 7. Age (In yrs. last b	oirthday) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min		ear) Counti	ace (State or Foreign
	D		Usual Residence of Decedent			1 2 4		
	arylar show	-	10a. State 10b. County	10c. City, Too	wn or Location		10	d. Inside City Limits 1 Yes 2 No
	the M	recto	10e. Street and Number	Bu	1 timore	10g.	Citizen of What Count	
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	304 N. Chane	1 Gate Ln. Apt.	H 21229		USA	
	lems (Iner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (: tf Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - America Black, White, e	
00036	hours after tural', or ite	by Fi	1 Never Married 2 Marrie 3 Widowed 4 Divorced	ed 1 Yes 2 No VYes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: B	ack
ş	J within 72 hours after death with the Marylan Jiene. r then "natural", or items 23a or 28a-f show I're Madical Examinat musi be notified at		15. Decedent'.		a. Decedent's Usual Occupation (Give kind of work done during most of wo	ndking 16	o. Kind of Business/Inde	ustry
Z	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO NOT use retired)		Allest	•
7 0	be filed within tal Hygiene. ad other then "	e Co	17. Father's Name (First, Middle, L	act)-	18. Mother's Na	me (First, Middle, Mai	den Sumame)	
au	ed is be	To Be	James E.	trazier.	Bar	bara 1	Jorns	
Mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationsh		9b. Mailing Address (Street and Number or F	iwal Route Number, C	ity or Town, State, Zip	Code)
6,≥	s 1 and if Health item 27 other tr		Kimberkigh I	rich burg/Siskr 3	of Disposition (Name of	Voudlawn	Location - City or Tov	X 7 T
101	00-		1 Burial 2 Cremation 4 Donation 5 Other (Sp	3 □Removal from State	tery, crematory er other place)	20/05 0	41 /	Is MD
alt	교 된 원 분 .		21. Signature of Funeral Service		22 Wire and Address of Family	ne Feneral	Services	10/10
g —	Depa Impo any i	L	Maugh C. M	leene	8728 Liberty Rol.	Rendalls	fown, MD.	21133
			22a Part 1 Eter the disease or				The state of the s	
			shock, or heart failure. List of	only one cause on each line.	o not enter the mode of dying, such as cardia	ac or respiratory arrest	111	Approximate Interval Between Onset and Death
	Physician /Medical		shock, or heart failure. List of the shock of heart failure. List of the shock of the shock of heart failure. List of the shock of heart failure. List of the shock of heart failure. List of the shock of heart failure.	a.Presumed	Preumocystis C	ac or respiratory arrest	111	Interval Between
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			1 - State Registrar Ce	partment of Health and Me ertificate of Death		ne No.2005 23201
	Physic	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	/Medi		ANNA Margaret 4a. Facility Name (If not institution, give street and number)	FROST 4b. City, Town, or Location of Death	JULY	13 2005 5:45 AM
	Examir	ıer	JOHNS HOPKINS HOSPITAL	BALTIMORE	CITY	4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	1	B. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
	Director		215-14-4574 1☐ M 2☑ F 83 Yrs. Usual Residence of Decedent		Aug 15,	
	the Maryland r 28a-f show notified ut	_	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Ba-fs	Director	Maryland Baltimore Catonsvil	lle		1 ☐ Yes 2 ☑ No
	with the	吉	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	Jeath ms 23	Funeral	719 Maiden Choice Lane BR606 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was December of Hispanic Origin? (Spec	it. Vos es No	USA 14. Race - American Indian.
9	after death v or Items 23a	E	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.)	Black, White, etc.
003		d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: White
21215-0036	72	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Industry
12	within iene. than "	dmo	College (1-4or 5+)	et Analyst		004
	e filed Il Hyg other	0	17. Father's Name (First, Middle, Last)	18. Mother's Name (overnment - SSA on Sumame)
ylar	Menta Menta arked	To B	George M. Knabe	Bessie	Ford	
Maryland	ges 1 and 2 should be filed within tof Health and Mental Hygiene. If Item 27 Is marked other than or other traumatic event, the Mental traumatic event.			ing Address (Street and Number or Rural I		
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Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If Item 27 It any injury or other tra once.		- Zesanar e E sismation o En lamova nom otate (77	osition (Name of Date matory or other place) Cemetery 7/19/	2005	Location - City or Town, State
Ħ	permit. Pa Departmen Important: any injury	j		2. Name and Address of Facility	WOO	dlawn, Maryland
ñ	Depariment Department		MINION MARIE	Sterling Ashton Sch 736 Edmondson Avenu	wab Funer	al Home, Inc.
	- 401		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between
H	Physician	5 1	Immediate Cause (Final disease or condition ACUTE MYELD	ID LEUKEMIA		Onset and Death
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al H	iclan: The certificate harector, page				performed? 1 ☐ Yes 2 X No	death?
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ion	nding Phath.	atloi	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	f 28c. Injury at 28c Work? M 1 ☐ Yes 2 ☐ No		ny socialist
Division	I or Attendi after death. Director; A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f.	. Location (Street as City or Town, State	nd Number or Rural Route Number,
Q	spital or cours afte neral Dir filled in					
	Fr 4 P S	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death (Check only one) and manner stated	n occurred at the time, date and place, and vestigation, in my opinion, death occurred	due to the cause(s at the time, date an	i) and manner as stated. d place, and due to the cause(s)
	To the Hos within 24 h To the Fur completely		one) and manner stated. 29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
	->-0		Winds MD	RES-000		-1 13 2005
	22		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		
	7		ROBIN VEIDT GOO NORTH WOLF	E STREET BALTI	MORE	MARYLAND 21287
F	Stat Registra		31. Date filed (Month, Day, Year) JUL 1 5 2005	E STREET BALTI	,	

amend item#23e, per H), C845, 1725/05 II
State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9 11:53P [™] Mary Patrick Gilbert July. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 01ney Montgomery 4508 Prestwood Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye June 28, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year) Days Months Hours 1 □ M 2 🕅 F Yrs. 1926 Indiana 314-22-5319 79 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or itama 23a or 28a-f show traumatic event, the Medical Exteniner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Olney Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20832 United States 4508 Prestwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ant: if itam 27 is markad o Dortha Opal Zachary Ernest Patrick ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Gilbert/Husband 4508 Prestwood Drive, Olney, Maryland othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 12, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. Norbeck Memorial Park 2005 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue 21. Signature of Funeral Service Licensee Rockville, Inc. 300 Rockville, Maryland West Montgomery Avenue 20850-2805 M00803 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Months Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 4☐ Pregnant at time of death detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 2√2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t autopsy perform 1□ Yes 2X No 1 ☐ Yes 2 ☐ No certificate Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death, investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or To the Hospital within 24 hours a To the Funeral I 1 🖄 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42652 July 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20832 18111 Prince Philip Drive, #327, Olney, Maryland Chitra Rajacopal, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 5 2005

32. Registrar's Signature

German, Ruth 7-4-05C 4:10AM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar 23203 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** July 4, 2005 4:10 AM M Ruth Garman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛱 F Yrs. 94 Sept 8, 1910 Ohio Director <u> 216-05-3078</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic avent." 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☑ No Directo Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 123 Northwood Drive USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 0 homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Walter Blankschaen Clara Gerstenberger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Susan Garman/daughter 2205 Sheridan Drive Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 \ Donation 5 □ Other (Specify) 21. Signaure of Emeral Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Immediate Cause (Final meta static FIREAST **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
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Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25,205 2005 , uno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Charle St. Balto md 2120x

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 5 2005

Biren & forles

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.) 2. Date of Death Decedent's Name (First, Middle, Last) Day **Physician** 07 ron 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Baltimore DON SPOONS HE 8. Date of Birth (Month, Day, Year) Mar 10, 19 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours unk 1 M 2 □ F 60 Yrs. 1945 218-44-7161 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b. County 28a-f show it of Health and Mental Hygiene. If itam 27 Is marked other than "natural", or Itams 23a or 28a-f show or other traumetic ayant, It o Medical Examinar must be multified at 1√ Yes 2 No Be Completed by Funeral Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1217 W. Fayette Street 21223 USA filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) disabled unk none unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 2000 W. Baltimore Street Baltimore, MD Bon Secours Hospital 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. ō 4 □ Donation 5 ☑ Other (Specify) in state Funeral Suice Licensee Rouald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MĎ elle caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deat 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: use 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year To Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital 1 Inpatient 2 □ ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deat 28a Date of Injury 28b. Time of Naturai Certification: (Month, Day Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Accident after death Diractor: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide ģ determined 4 Homicide within 24 hours a To the Funaral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) 29b. Signature and title of State JUL 1 5 2005 Registrar

		1 - For State Registraramend item #2 1. Decedent's Name (First, Middle, Last)	20a per ana bo	1 g Ger tifi	cate pf-Pg	eath 	2. Date of Deat	eg. No. 2 0 (5 27 20 20 An 5
Physic /Med		FREO	61	RAYE	BEAL		Month 7	Day 06 2	55 1215AM
Exam		4a. Fecility Name (If not institution, give str	eet and number) NSG REHM	9B 4b	City, Town, or Loc BALTIII	NORE		4c. County of	Death
Funera Director		5. Social Security Number 22/124/12 6. Sex 124 124 124 124 124 124 124 124 124 124	7. Age (In yrs. las			Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Dec 30,	Year) 1921 M	Birthplace (State or Foreign Country) aryland
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h with the 23a or 28a	Funeral Director	10e. Street and Number 50/ W. FRA/	VKLIN ST	- 1	Of, Zip Code	201	1	0g. Citizen of Wh	at Country?
<u> </u>	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Morvorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was	Decedent of Hispa s, specify Cuban, M Yes 2 No S	nic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		American Indian, White, etc.
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Maryiana Z nd 2 should be filed th and Mental Hygi t7 is marked other traumatic event, II.	To Be Co	17. Father's Name (First, Middle, Last)			unk 18.	. Mother's Name Zu1a	Johnson	Maiden Sumame)	
Mal y		19a. Informant's Name/Relationship (Type Bernice Graybeal/s			ddress <i>(Str</i> eet a <i>nd</i> mith Road			•	ate, Zip Code)
allimore, mit. Pages 1 an partment of Heal portant: If item 2 y injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Re Approximation 5 Other (Specify)	moval from State	ace of Dispositio metery, cremato	n (Name of ry or other place)	D	ate	20c. Location - Ci	ty or Town, State
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Of VICAL P Physician: Th this certiticate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	Other	3. Place of Death 4 Nursing Hor		ence 6 Other	(Specify)
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ital or Att its after de ral Directe led in by t		3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Tow	n, State)	or Rural Route Number,
DIVISION To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Medical	(Check only 2 Medical Examin one)	cien: To the best of my know er: On the basis of examination and manner stated.	vledge, death oc on and/or invest	igation, in my opinion	on, death occurre	ed at the time, d	ate and place, an	d due to the cause(s) Month, Day, Year)
To with	~	29b. Signature and title of certifier	2016		DI	7537		7-6-	-05
		30. Name and address of person who core DALSHANS 31. Date filed (Month Day Year)	npleted cause of death (Item :	23a) (Type, Prir	MOUN;	1 Foy	of Ave	, Isalt	021417
Regis	tate trar	31. Date filed (Month, Day, Year) 15 2005	32. Registrar's Signatu	post					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1 1 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month X005 11:10P. N Physician HAMMETI KRNESTINE DINGLE JULC /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rifchie BALTINORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) HOS 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 Ø F SUMMERTON S.C 217-26-1246 IUNE Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23s or 28a-f ehow idical Examiner must be notified at 1 Yes 2 No mo Baltimore Directo 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 457 Walton 21201 U.S. A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ACK Completed by 3 ₩idowed 4 Divorced it Sirver.
In and Mental Hygiene.
If is marked other than "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) rome to we wife 104 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be f Department of Health and Mental I DING VICTORIA GIASON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) / Augh RR BALTIMORE, Md. 21201 Important: If item 27 is any injury or other training. GLORIA 457 WALTON CT. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 14/05 4 □Donation 5 □ Other (Specify) Batto Md. MT. ZION GENETAGE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Capacit Rollins Function Name Frico. Ms. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic **Physician** colon cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician ar P.O. Box 68760, Physician/Medicai IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has birector, page 2 s autopsy performed? Yes 2 No 2 No 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After t To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD Richey Hospice 838 N So Eutaw 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 5 2005 Registrar

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SAITIMOFE permit. Pages 1 Department of He important: if iter any injury or oth		• 4 □ Donation	Other (Specify) eral Service License		Cou	UNSVIII	e Vet.	Cemelel	CITA.	05		nsville	Mo	-
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12.5			e dir ase, or come le failure. List only on	cations that caused e cause on each line	the death	n. Do not ente	er the mode	of dying, such a	as cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death	
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DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alter completely filled in by the fune	Certification;	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubulding, etc.	ry - At ho . (Specif	ome, farm, str	reet, factory,	office	28	Bf. Location (City or To		l Number or Ru	ral Route Number,	
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To the within To the comple	Me	29b. Signature and	title of certifier				29c.	License numbe	or C		29d. Date	e signed (Mont/	n, Day, Year)	
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10 /Medical ity, Town, or L. BALTI MORL Vaar If Under 24 Hrs. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HUC Birthplace (State or Foreign Country) If Under 1 Year Months Days Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 69 Year) Months 100 M 2□ F MARYLAND -24.42 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a State or 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-1 shov traumatic event, the Medical Expander must be notified at Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
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4 ☐ Donation 5 ☐ Other (Specify) 1-13-05 BALTIMORE, MO 22. Name and Address of Ficility 2325 YORK PD, TIMON INM MONING 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PEACEFULALTERNATTIVES FUNEDALIC Approximate TR Interval Between Onset and Death Immediate Cause (Final **Physician** mony disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dicheter Mell, of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed perteneia Due to (of as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by sign. 3 Dobably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □ Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Medical Certification; To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 Natural 2 □ No 1 TYes 2 Accident Director: 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral C Tecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 1/2001

ORIGINAL

CPM 05-04659 Stephen Hall

pnei	nall		For State	State of Mary	land / Depa	artment of H	lealth and	Mental Hyg -	iene 2005	23209
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	ath with the Marylan 23a or 28e-f ehow	ector	MD BALTI	MORE	mi	10f. Zip Code			l 0g. Citizen of What C	1 ☐ Yes 2 (No
	3a or 2	Funeral Director	10e. Street and Number	mer Ro		101. 21p Code	1102		USA	-
	itemesi Itemes	uner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
036	E o a	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No II Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Specify: W	hite.
21215-0036		Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo d)	rking	16b. Kind of Business	/Industry
212	il Hygiene. other than other, in a Max	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Tech	micia		(First Middle	Hutomo-	five
Maryland	s 1 and 2 should be filed withir f Health and Mental Hygiene. Item 27 le marked other than other treumatic event, tra Mi	To Be	17. Father's Name (First, Middle, Last)	d Hall:	SR.		Cha (me (First, Middle,	EARCH SUMAMO)	ton
Aary	2 should be and Mental 1e marked reumatic ev		19a. Informant's Name/Relationship (Type, Print)	19b. Mailii	ng Address (Street	and Number or R	ural Raute Numbe	r, City o Town, State,	Zip Code)
	is 1 and 2 of Health of Item 27 I		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place	I I GET	Date Date	20c. Location - City or	Town, State
Baltimore,			1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)			wal Chap	el-BolAir	7-4-05	Forest	HII, MD
Ball	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice	WIN AR	ρ_{k}^{2}	ACF GILAL	5325 YOU	EK RD, TI	MONIOM M	D 2/093 TIGNY FUTER
1			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications to to aused the one cause on each line.	eath. Do not en	ter the mode of dyin				Approximate Interval Between Onset and Death
J.	Fnysician /Medical	9 1	Immediate Cause (Final disease or condition resulting in death)	a		runic alcel	helism			Olisai and Deam
	Examiner		Sequentially list conditions,	b						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of):					
90,	cate be executed ohysicien and the burial-transit	I Exa	resulting in death) Last	Due to (or as a co	onsequence of):					li li
68760,		ledical		d						
Вох	leath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of de Month	olivery Day Year
P.O.	at the de by the tached	hysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	30					
	quires tha in signed uld be de	٥	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.		bacco use contribute t es 2□No 3□P	. 1
Vital Records,	The law requires that the death certify ate has been signed by the attending page 2 should be detached for use as	Completed						24a. Was autop	med? death?	utopsy findings available completion of cause of
ital	ician: Th certificate ector, pag	Be Co	25. Was case referred to medical examiner?					1 DXYes ath (Check only of	2 No 1 Ye	s 2□No
of \	Phys this al dir	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatre		4 Indising		ence 6 XX ther (Spe ow injury occurred	ecity) SCENE
Division of	uttending I death. ctor; After y the funer	cation	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b			M 1 🗆	k? Yes 2 □No			
Divi	s after dail Direct	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, st Specify)	reet, factory, office		281. Location (S City or Tow	itreet and Number or R n, State)	lural Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical		nysician: To the best of n niner: On the basis of ex and manner stated	amination and/or in					
	To the within 2 To the complete	Ž	29b. Signature and title of certifier	11	-/_	29c. Licens			July 12, 2	
1	6		30. Name and address of person wo	completed cause of deat	h (Item 23a) (Type,				•	
			JA(K 31, Date filed (Month, Day, Year)	completed cause of deat M. Tikus 32. Registrar's			n Street	t Baltin	ore, Maryl	and 21201
	Sta Regist		JUL 1		w K	Coaste				

			For State Registrar	State of Marylar	•	artment of H		•	giene)
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month	- / +++	3. Time of Peat
	Physici: /Medic		RUTH	HOUC	CK			07	04 20	005 4:25а.м.
	Examin		4a. Facility Name (If not institution, give str MARINER HEALTH OF			4b. City, Town, or FOREST		h	4c. County of D	
-	Francis		5. Social Security Number 6. Sex		. last birthday)	If Under 1 Year	If Under 24 Hrs		9.	Birthplace (State or Foreign
	Funeral Director			^{4 2} ∑F 89	Yrs.	Months Days	Hours Min.	Sept 11	, 1915 N	orth Carolina
	pur x		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation		-		10d. Inside City Limits
	Maryla faho iedal	ō	MD Harford		orest H					1 ☐ Yes 2 € No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	23a c		109 Forest Valley				21050		USA	
	ltems	Funeral	11. Marital Status 1 Never Married 2 Married	. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
20	urs aft	ρ	3 Widowed 4 □ Divorced	1 □Yes 2 17 No If Yes, Give A Year or Dates:		1 ☐ Yes 2√ No	Specify:		Specify: T	white
۲ ک	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or tlems 23a or 28a-f ahow int, the Mazical Examinat must be notified at	Completed	15. Decedent's Educa (Specify only highest grade	tion completed)	(Give	dent's Usual Occupa	turing most of wo	rking	16b. Kind of Busine	ess/Industry
2	within jiene.	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired memaker)		own hom	ne
מ	e filed within al Hygiene. other than vent, the My	Be Co	17. Father's Name (First, Middle, Last)		110		18. Mother's Nar	me (First, Middle,	Maiden Sumame)	
/lar	0 0 0	To B	Hardin Montsey Wa	tson			Alice C	Cornelia	Cook	
Maryland 21215-0036	tra tra		19a. Informant's Name/Relationship (Type Alice Houck/daugh			ng Address <i>(Str</i> eet a Green Ro			r, City or Town, Stai 1013	te, Zip Code)
ore,	es 1 ar of Hea of Hea of Hea of Hea		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispo cemetery, crea	osition (Name of matory or other plac	θ)	Date	20c. Location - City	or Town, State
Baltimore,	permit. Pages Department of Important: If It any injury or o		*4 ☑ Donation 5 ☐ Other (Specify) 21. Signature I Funeral Sept. Licensee		22	2. Name and Addres	ss of Facility	1 (55 1)	Baltimore	
ñ	Dep Imp		hetta la Se We	ige, pureeto:						e Street
			23a. Parti Enter the disease, or complicion shock or heart failure. List only one	cause on each line.				c or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	ends	20	lumber				Onset and Doun
	/Medical Examiner			Due to (or as a conse	que of):					
١.	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):					
,	death certificate be executed e attending physician and nd for use as the burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a conse	quençe of):					
8760	ate be nysicia he bur	dicai	d.							
9	ertifica ling pt e as tl	Med	IF FEMALE:	c. If yes, outcome of pregr	20004					
Вох	eath certific attending p	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Fet	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
Р. О.	the d	hysi	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown						
	The law requires that the de tte has been signed by the a bage 2 should be detached t	by	Part II. Other significent conditions conti	ibuting to death but not re	esulting in the u	nderlying cause give	en in Part I.			te to the cause of death? Probably 4 Dunknown
Records,	w require been slo should b	letec	ie al 7		Our.	- de		24a. Was a	an 24b. Were	e autopsy findings available
Re	hysician: The law his certificate has t I director, page 2 s	Completed	trong o to	and pu		1	7	autop: perfor	sy prior	to completion of cause of h?
Viital		Be C	25. Was case referred to medical examiner?				*	ath (Check only or		
	Physic this ce	10	1 ☐ Yes 2 No		ER/Outpatie		4 Nursing I		ence 6 Other (S	Specify)
ono	ding h. h. After funer	tion	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Worl	vat k? Yes 2 □ No	200. Describe II	ow injury occurred	
Division of	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	pitel o		29a. Certifier 1 Certifying Physi	cian: To the best of my kr	nowledge deat	h occurred at the tin	ne date and place	and due to the o	Pause(s) and manne	or as stated
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	ledical	(Check only 2 Medical Examina one)	er: On the basis of examinand manner stated.		vestigation, in my o	pinion, death occi	urred at the time, o	date and place, and	due to the cause(s)
	with To 1	Σ	29b. Signature and title of certifier			29c. Licensi	_	1	29d. Date signed (M	oonin, Day, Year)
E			30. Name and address of person who con	unleted cause of death (tre	am 23a) (Tune		2259		July 6	, 200
			DR. MANUEL LAZATI			BERDEEN,	MD 2100)1	0.	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign						
	Regist	rar	JUL 1 5 200	5 Bleever.	A PS	arle				

•			For State Registrar	State of M	•	epartme <i>Certifica</i>			and Me		giene Reg. No. 2005	23211
	Physici		1. Decedent's Name (First, Middle, MARGA)	227 H	0//41	D				Date of Dea Month	Day Year	3. Time of Death
4	/Medio		4a. Facility Name (If not institution,	give street and number)	Cana	4b. Cit	RAN	Location o	of Death	w	4c. County of Dea	ignz
	Funeral Director		5. Social Security Number 219–18–9568 Usual Residence of Decedent	6. Set 7. Ag	ge (In yrs. last birt 82	Yrs. Month:	er 1 Year Days	If Under a	Min. F	Date of Birtl (Month, Day ebruary	23, 1923 Ma	thplace (State or Foreign Suntry) ry land
	Maryland -f show	tor	10a. State 10b. County	ı/a	10c. City, Town	or Location						10d. Inside City Limits 1 □ Y es 2 □ No
	death with the Maryland ms 23e or 28e-f show Littual be mailthed at	Funeral Director	10e. Street and Number 3706 Edgertor	n Road		10f. Z	ip Code 212	15			10g. Citizen of What Co	puntry?
5-0036	n 72 hours after death with the Marylan "naturel", or Hems 23e or 28e-f show exists Examiner must be institled at	by	11. Marital Status 1 Never Married 2 Marrie 3 Widowed AXDivorced	12. Was Decedent Armed Forces? ad 1 Tyes 2 If Yes, Give Year or Dates:	Ever in U.S. No		edent of Hi ecify Cuba 2X No	spanic Orig n, Mexican Specify:	gin? (Speci , Puerto Rí	ty Yes or No- can, etc.)		
21215-0	s filed within 72 ho I Hygiene. other then "natur rent. The Medical	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	s Education grade completed)		Decedent's Us (Give kind of v life. DO NOT role &	rork done d use retired	luring most ')			16b. Kind of Business State of M	
Maryland 2	s 1 and 2 should be filed with! f Health and Mental Hygiene. item 27 is marked other than other traumatic event. Its M	To Be C	17. Father's Name (First, Middle, L John	Marshall					r's Name (i Elbia	First, Middle,	Maiden Sumame) Latne	у
Mary	nd 2 sho alth and 1 27 is ma		19a. Informant's Name/Relationsh			•					r, City or Town, State, . ore, MD 21	Zip Code) 212
Baltimore,	permit. Pages 1 and Department of Heall Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 IX Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (Sp	ecify)	Marylan	Disposition (N y, crematory of d Nat'l N	other plac 1em 1 F	Park	7/18/C)5	20c. Location - City or Laurel, MD	
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service L			1050	ork Ro	d., Tow	vson, M	D 2120		
	Pnysician /Medical Examiner	her	23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter the disease or injury.	aDue to (or as	a consequence of a cons	S of): AAZE			Cardiac or r		rest,	Approximate Interval Between Onset and Death
8760,	certificate be executed ding physician and ise as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of	of):						
.O. Box 6	death s atter d for u	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pyegnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic 5 □ Other (23d. Date of de Month	livery Day Year
۵.	es og pe	d by PI	Part II. Dther significant condition A Gut TE	es contributing to death b		the underlying	cause give	en in Part I.			bacco use contribute to es 2 □ No 3 □ Pt	the cause of death?
Vital Records,	e law has b	omplete	ATRIAL RESPIRED	FIBRILL	fired here					24a. Was a autop perfor	sy prior to death?	utopsy findings available completion of cause of
	ilcian; certific rector,	Be	25. Was case referred todical examiner? 1 ☐ Yes 2 ☐ No	Heantah /	ent 2 ER/Ou	tpatient 3 1	Othe	200		Check only or	ence 6 Other (Spe	cifu)
Division of	ffe neg	Certification: To	27. Mann of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide	28a. Date of Inju (Month, Date) ation 28e. Place of In	iry 28b. T	ime of njury M	28c. Injury Work 1 🔲 `		28- No	d. Describe h	ow injury occurred	
Ō	To the Hospitei or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Cert	29a. Certifier 1 V ertifying	Physician: To the best miner: On the basis of and manner st	of examination and					d due to the c	cause(s) and manner as	
	To the within To the comple	Me	29b. Signature and title of ertifier	and	per	2	9c, License	number	2_	2	29d. Date signed (Mont	h, Day, Year)
	100		30. Name and address of person of	Conquir	V hus	Type, Print)	12	NO	MISTE	NU.	HepitA	1 Caren
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 5 2	2. Registr	rar's Signature	book					/	

			For State Registrar			of Ma	aryland	-	artmen rtificate				lental Hy	Reg. N		5	232	12
	Physici	an	Decedent's Name										2. Date of Do Month	Da	ay Ye	ear	3. Time of	Death
	/Media	cal	4a. Facility Name (If		Mildre		riga	n	4h City	Tour	Location	of Dooth	July 9	-	005 c. County of I	Dogeth	1:00	A M
	Examir	ner			nor Nur		Home		4D. City,		wson			"		timo	re	
	Funeral		5. Social Security N		6. Sex	7. Ag		ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi	th			ce (State o	r Foreign
	Director		218-40-0		1 □ M 2 💢	F	93	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di Nov. 1	1, 1	911	Mary	land	
	and w		Usual Residence of 10a, State	Decedent 10b. County			10c. City	, Town or Lo	cation							100	d. Inside Cir	tv Limits
	Maryli	٥	Md.	N/A			Balt	imore									1 X Yes	2 🗌 No
	r 28e	rect	10e. Street and Nun	nber					10f. Zip	Code		***		10g. C	itizen of Wha	it Countr	y?	
	th with 230 o	by Funeral Director	742 Ann	eslie R	d.					212	12					USA		
	r dea	ner	11. Marital Status		Armed	Decedent d Forces?		S. 13.	Was Deced	lent of His	spanic Ori	gin? (Spen, Puerto	ecify Yes or No Rican, etc.)	>-	14. Race - A Black, V	Americar White, et		
36	rs afte	y Fi	1 ☐ Never Marrio 3 ☑ Widowed		If Yes	es 2∭.↑ , Give or Dates:	lo		1 ☐ Yes 2	2 X] No	Specify:			İ	Specify:	Wł	nite	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or tlems 23e or 28e-f show the Medical Exam me must be notified at	led		15. Decedent	s Education			16a. Dece	dent's Usua	i Occupa	tion			16b. i	Kind of Busin	ess/Indu	stry	
215	thin 7.	Completed	Elementary/Secon		t grade complet		+)		kind of wor DO NOT us	rk done d se retired)	uring mos	t ot worki	ng					
21	ed wil	Con			1	je (1-4or 5 5+		Teac	her		40 11-11-	. d. M	(F)		lucatio	on		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel; or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	To Be	17. Father's Name (Roush	.ast)							i th	(First, Middle Kath		-			
Jan	2 sho		19a. Informant's Na						-				Milla	-			ode)	
e,	1 and Health em 27 ther t		Mary Kle-		griter		20b. Pla	ace of Dispo					Mills,		ocation - City		n. State	
nor	ages ant of t: If it			Cremation	3 Removal fr	om State	1	_{imetery, cre} i vonia				3-1-0	15		ersbur			
Baltimore,	nit. F partme ortan Injur		21. Signature of Fu			7	La	22	Name an	d Address	s of Facilit	hv				9, 1	u •	
ä	Departing Permi		1/	1 1.	7-2		-	···	1050	lows	on Fi	inera Tows	1 Home	, In 21	C. 204			
	3		23a. Part1. Enter the shock, or hear	e disease, or o	com lications th	at caused on each lin	the death.	. Do not ent	er the mode	e of dying	, such as	cardiac o	or respiratory a	rrest,		16	oproximate nterval Bety	veen
	Physician		Immediate Cause (disease or condition	Final n	. Atl	uros	den	otic	cardi	D- V	ascu	lar	disea	se			Vecur	
	/Medical Examiner		resulting in death)	1		to (or as											1	
		<u>-</u>	Sequentially list cor	nditions,	b. — Dus	to (or ear	s consequ	ianou of):										
	uted d ansit	Examiner	cause. Enter Under Cause (Disease or that initiated events	rlying injury	G													
oʻ	an an rial-tr	Exa	resulting in death) L	ast		to (or as	consequ	ence of):										
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical		1	d													
39 ×	death certifica attending ph d for use as th	Physician/Med	IF FEMALE:		23c. If yes,	outcome	of pregnan	201/								1		
Вох	attend for us	cian	23b. Was decedent in the past 12	months?	1 Li	ve birth regnant at	2 Fetal	death 3	Ectopic pro						23d. Date of Month		ay Y	'ear
o.	that the de ned by the a detached f	ysle	1 ☐ Yes 2 🕽 9 ☐ Unknown	No		nknown				,,								
٦,	uires that signed b d be deta	by Pt	Part II. Other signifi	cant condition	ns contributing t	to death bi	it not resul	Iting in the u	nderlying ca	ause give	n in Part I.		23e. Did 1	obacco	use contribut	te to the	cause of de	eath?
rds	w require been sig should b	pa											1 🗆	Yes 2	□No 3□	Probab	ily 4 🚉 t	nknown
Records,	ne law ru has be ge 2 sho	Completed											24a. Was		prior	to comp	y findings a	vailable luse of
E B	to an	Con											perfo 1 ☐ Yes	rmed? 2 X No	deat		□ No	
Vital	Physiclen: Th this certificate ral director, pag	Be	25. Was case referr examiner?		Hospital:					Othe			(Check only o					
o	Phys this ral di	- To	1 ☐ Yes 2 2 1		1	Inpatie ate of Injur		R/Outpatier 28b. Time of	_	A	4 Nu		me 5 Resi 28d. Describe			Specify)		
O	ding I th: After funer	tlon	1 Natural 2 Accident	5 Pending investiga		ate of Injur Aonth, Day	Year)	Injury	М	3c. Injury Work' 1 □ Y	? es 2 □							
Division	l or Attending after death. Director: After I in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	286. PI	lace of Inju	ry - At hor . (Specify)	me, farm, str	eet, factory	office			28f. Location (City or To			r Rural F	Route Numb	per,
Q	pitel o			·Marian	Di di i													
	To the Hospitel or Attentwithin 24 hours after death To tha Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	2 Medical E	Physician: To examiner: On the and n	the best of e basis of nanner sta	examination	viedge, deati on and/or in	occurred a restigation,	in my opi	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s date an) and manne d place, and	r as state due to th	ed. 1e cause(s)	
	Tol	2	29b. Signature and	4.7			и			License				_	te signed (M		y, Year)	-
	1		Mal		villes		·			514	> Y			Ju	ly 13,	1 0	w>	
1	h.			York 1	Road 1	Sur	eath (Item:	23a) (Type,	Print) uthe	rvill	e,	Mi) 21	09	3			
	Sta Registr		31. Date filed (Mont	UL 15	2005	Registra	r's Signati	ure	We									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Physician MAIR 2005 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give Examiner THARE ti Marc Year If Under 24 H 7. Age (In yrs. last birthday) If Under 1 6. Sex Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 □ Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati 10d. Inside City Limits itam 27 la marked other than "netural", or Itams 23s or 28a-1 show other traumatic avent, the Medical Eventual the notified at 1 Yes 2 □ No Director yar 10g. Citizen of What Country? Completed by Funeral Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Neyer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NGT use retired)

HOMEMALY 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental Kick OLASO 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 it any injury or other tra TIMOR lan 20a. Method of Disposition
1 Surial 2 ☐ Cremation 20b. Place of Disposition (Name of 3 ☐Removal from State * 4 □Donation 5 □Other (Specify) 21. Signature of Juperal Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of) certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy certificate 2□No 1 ☐ Yes Yes of Vital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🗆 Yes 1 Inpatient မ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident completely filled in by the within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL ARIOSA. BAGEY, MD 31. Date liled (Month, Day, Year) 32. Reistrar's Signature State JUL 1 5 2005 Registrar

			For State	State of M	laryland / Depa		of Health a		, 0		
			Registrar 1. Decedent's Name (First, Middle,	Last)		imodic	Or Douis	2. Date	Reg. I	10.2005	3. Time of Death Li
н	Physici		Constantino	G.	He	on		Month Tu 1 se		2005	0540A M
	/Medio Examir		4a. Facility Name (If not institution	give street and number)		wn, or Location			4c. County of Deat	
4	LXdiiii	iei	Adventist Rehal	oilitation	Hospital	Pock	ville			Montgome	rv
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 \	Year If Under	24 Hrs. 8. Date of	of Birth	9. Birth	hplace (State or Foreign untry)
ь	Director		579-42-4178	1 X M 2 □ F	74 Yrs.	Months D	Days Hours	Min. (Monti	of Birth 1, Day, Yea 30,	1931 Was	hington, DC
	p ,		Usual Residence of Decedent		100 City Town						
	shov	-	10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	8a-f	cto	Maryland Montgo	nery	Rockville	1					11 Yes 2 No
	vith th	Dire	10e. Street and Number			10f. Zip Co			10g.	Citizen of What Co	untry?
	s 23s	by Funeral Director	8 Marcus Court	1.00		208				ited Stat	
	er de itam	une	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S. 13. V	Mas Deceden f Yes, specify	nt of Hispanic Ori Cuban, Mexicar	igin? (Specify Yes on, Puerto Rican, etc	r No- .)	14. Race - Ame Black, White	
36	rs aft	λ.	1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	No Korean Conflict	1 ☐ Yes 2 🛚	No Specify:			Specify: Uh	ite
21215-0036	72 hours after death with the Maryland Inatural; or Itams 23a or 28a-1 show dical Examinat must be notified at	ed	15. Decedent's			dent's Usual C	Occupation		16b	Kind of Business/	
15	n na	Completed	(Specify only highest	grade completed)	(Give		done durina mos	t of working	100	Trans or Dustriosari	ridustry
212	d within jiene. r than "	шо	Elementary/Secondary (0-12)	College (1-4or 2	Bu	siness	3		Se	elf-Emplo	yed
	e filed Il Hygie other	BeC	17. Father's Name (First, Middle, L.	ast)			18. Mothe	er's Name (First, M	ddle, Maid	en Sumame)	-
<u>a</u>	Ald be Alental rked o	To B	George C. Heo	n			Ifi	genia Lec	nardo	opoulos	
Maryland	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 show any njury or other traumatic evant, the Mudical Examiner must be notified at once.		19a. Informant's Name/Relationshi	ip (Type, Print)	19b. Mailir	ng Address (S	Street and Number	er or Rural Route N	umber, Cit	y or Town, State, Z	îp Code)
	and 2 ealth on 27 i		Helen Heon/Wif	e	8 Ma	rcus C	Court, R	ockville,	Mary	1and 20	850
Baltimore,	of He		20a. Method of Disposition 1 🖾 Burial 2 🔲 Cremation	0 - 0	20b. Place of Dispo	natory or othe	er place)	July 15,	20c.	Location - City or	Γown, State
Ĕ	Pages nent of int: If it.		'4 □Donation 5 □ Other (Sp.		' Parklawn	Memori	ial	2005	Roo	ckville,	Marvland
alti	permit. Departn Imports any nju		21. Signalu Tot Fu eral Service L	icerse	22 D. c	Name and A	Address of Facility	Rolert A	. Pur	nphrey Fu	neral Home/ Avenue
Ω	8 5 E 5 8		3 Garalle	Jeur.	M00803 RC	ckvi11	e, Mary	1and 208	50-28	305	Avenue
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause	ed the death. Do not ent						Approximate Interval Between
ж	Pnysician		Immediate Cause (Final disease or condition		iovascular	Diseas	e			1	Onset and Death
4	/Medical		resulting in death)	a	s a consequence of):				1		OME
п	Examiner		Sequentially list conditions	b. ————		0		1	1	/ MO	Db.~
	שָּׁ מַ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs [Disease or injury	Due to (or as	s a consequence of):	11			[W	
	acute Ind trans	Examiner	that initiated events resulting in death) Last	c			\		YV		/
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8760,	death certificate be executed e attending physician and od for use as the burial-transit	dicai	'	d		-	do			11'	
9 ×	eath certific attending p	/Med	IF FEMALE:	23c. If yes, outcome	a of programmy		1)				
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregr				23d. Date of delifi Month	very Day Year
o.	at the de by the a tached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	at time of death 5	Other (special	my)		_		·
Ω.	de ad	h Ph	Part II. Other significant condition	s contributing to death	but not resulting in the ur	nderlying caus	se given in Part I	23e.	Did tobacc	o use contribute to	the cause of death?
Records,	signe d be	d by	C1-C2 Fracture	-		, ,		1	1 🗌 Yes	2 No 3 Pro	bably 4 Unknown
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a			Chronic Obstru	ctive Pulmo	nary Diseas	se		1 N	es 2🛛	Vo 1 ☐ Yes	2 No
Vital		Be	25. Was case referred to medical examiner?	Hospital:	-5500		Othor	of Death (Check o			
of	Phys r this ral di	5. T	1 X Yes 2 No 27. Manner of Death		ient 2 ER/Outpatien		4[_] NU	rsing Home 5 28d, Desc		6 LJOther (Speci jury occurred	ify)
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Division	r Attanding er death. ractor: Atter by the fune	fica	3 ☐ Suicide 6 ☐ Could no	of be 28e. Place of In	niury - At home, farm, str			1011		and Number or Ru ate)8 Marcu	
ă	. 0 -	Certification;	4 Homicide determin	building, e Resid	lc.'(Specify) lence					¹⁶⁾ 8 Marcu , Marylan	
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying	Physicien: To the best	t of my knowledge, death	occurred at t	the time, date an	d place, and due to	the cause	(s) and manner as	stated.
	na Ho na Fu	edical	(Check only 2 Medicel E one)	xaminer: On the basis of and manner s	of examination and/or inv	vestigation, in	my opinion, dea	th occurred at the t	me, date a	and place, and due	to the cause(s)
	To the within To the comple	M	29b. Signature and title of certifier	ΛΛ -		29c. L	icense number		29d. [Date signed (Month	, Day, Year)
			1	1100)	חחת)59782		,Tı	ıly 11, 2	005
16	xd		30. Name and address of person w	no completed cause of	death (Item 23a) (Type,		,,,,,,,,			<u> </u>	003
20	1		Ruijin Yao, M.	D. 9909 Me	dical Cente	r Driv	re, Rock	ville, Ma	ry1aı	nd 20850	
	, Sta		31. Date filed (Month, Day, Year)	32. Req	trar's Signature	A					
	Registi	rar	JUL I	5 ZUUD	wer It	GOSME					

		1 - State Registrar AMEND ITEM #	State of Marylan 5 PER FH G84				-	giene _{Reg.} k 2.005	23215
Physic	ian	1. Decedent's Name (First, Middle, Last)	J. Hoover				2. Date of De Month	ath Day Ye	3. Time of Death
/Med Exami		4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, or	Location of Dea	<u>July</u>	11, 2005 4c. County of E	
. Funeral Director		213 11 -1-/	7. Age (In yrs.)	last birthday) Yrs.	Parks If Under 1 Year Months Days	7ille If Under 24 Hrs Hours Min			More Birthplace (State or Foreig Country) Maryland
show	J.	Usual Residence of Decedent 10a. State 10b. County Maryland Ball	10c. City	y, Town or Lo	cation Dunda	.11-			10d. Inside City Limits
with the M 3a or 28e-f	Director	10e. Street and Number 3001 Dunglow Roa			10f. Zip Code	21222		10g. Citizen of Wha	t Country?
d within 72 hours after death with the Maryland jiene. in then "natural", or itams 23a or 28e-1 show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (s in, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	. 14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
within ane.	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wo	orking	16b. Kind of Busin	
s 1 and 2 should be filed f Health and Menial Hygii itam 27 is marked other other traumatic avent, u	To Be Co	12 Years 17. Father's Name (First, Middle, Last) Julius Wood			ecretary		me (First, Middle, na E. Ja	Maiden Sumame)	La
is 1 and 2 shoot Health and itam 27 is m		19a. Informant's Name/Relationship (Type S. Sheldon Diggins	s (Attorney)	1406	Dundalk		Dundal	er, City or Town, Sta k, Maryla	nd 21222
permit. Pages 1 ar Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re ' 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, crer	sition (Name of natory or other plac ervice Co	· 1 .	3/2005	Towson,	or Town, State Maryland
permit. Depart Import any inj		21. Signatury of uneral Service License	Con		7922 Wise	Funera Ave. I	Dundalk,	f Dundalk Maryland	, Inc. 21222
Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death
cate be executed by spician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of the consequence of t	uence of):	otic 1	asw	lara	lissone	yrs.
death certifi e attending id for use as	Physician/Med	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown	c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
law requires that the as been signed by the 2 should be detache	þ	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.			e to the cause of death? Probably JUnknown
The ate h page	Completed						24a. Was autop perio 1 🗆 Yes		
ding Phys	tlon; To Be	25. Was case referred to medical examiner? 1 Yes No 27. Mamer of eath Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	Nursing I		fe) dence 6 □Other (S now injury occurred	Specify)
To the Hospitel or Attending within 24 hours after death. To the Funerel Director; Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (5 City or Ton	Street and Number of vn, State)	r Rural Route Number,
ha Hospii in 24 hour ha Funari pletely fills	edical	(Check only 2 Madical Examination	cian: To the best of my known. Pr: On the basis of examinate and manner stated.	tion and/or in	estigation, in my or	oinion, death occi	urred at the time, o	date and place, and	due to the cause(s)
To t withi To t	M	29b. Signature and title of certifier	npleted cause of death (Item Lul Lner MD) 32. Rustrar's Signal	Oer	29c. License	256 c	+3	29d. Date signed (<i>M</i>	onth, Day, Year)
10		30. Name and address of person who con Kendoll R. Fa	npleted cause of death (Item	23a) (Type,	Print) Cebel He	her Bl	ud/Ba	eltrae	WD 31334
St Regist	ate rar	31. Date filed (Month, Day Year) JUL 1 5 20	32. Registrar's Signal	ture /	perte				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

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			1. Decedent's Name	(First Middle La	est)		Cent	meate of	Dealit	2. Dete of De	Reg. No.)	5 232	1.7
	Physic	ian	Edwa		4/	2				Month	Day	Year Jane or	цеац
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	Exami	ner	. 1/	// /	e street end number,	PAST	DINTE	enab.	4b-Gity, Town, o	r Location of Deat	h 4c. County	of Death	
			YNUKSIN	CLENTER	C, 10460K	NOR	HYOIR	HA	WAITIN	noke	DA	41mores	-
	Funeral		5. Social Security Nu			ge (In yrs. lest	birthday)	If Under 1 Year Months Days		rs. 8. Date of Bi	th Vear	9. Birthplace (Stete o	or Foreign
	Director		212-48	-2183 /	M 2DF	58	Yrs.	WOITE Days	Tiours IVI	n. 8. Date of Bi	1-1946	LSA	
	D		Usuel Residence of	Decedent							-1		
	ylan		10a. Stete	10b. County		10c. City, To	own or Loca	ation				10d. Inside Ci	ity Limits
	Ma Had	Po	MD				Balti	more				1,□ Yes	2 □ No
	138 th	8	10e. Street end Num	ber		1	рател	10f. Zip Code			10g. Citizen of	Mhat Country?	
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	ath 23	20		ghes Ave			17		1219			SA	
	72 hours after death with the Maryland natural', or frems 23e or 28e-f show alsel Examiner must be nothing at	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?	?	13. W	as Decedent of I Yes, specify Cub	Hispenic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	o- 14. Rad	e - American Indian, ck, White, etc.	
36	aft.		1 Never Marrie		1 ☐ Yes 2 🗓 If Yes, Give	No		□Yes 2¶∑No					
215-0036	"natural",	Completed by	3 ☐ Widowed 4	I M Divorced	Year or Detes:						Specil	white	
5	72 ho	ě	(Specif	15. Decedent's Ed by only highest gra	ducetion	10	6a. Decede	nt's Usual Occup	petion	odking unk	16b. Kind of B	usiness/Industry	unk
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	Hygi other	Be	17. Father's Neme (F	First, Middle, Last,)				18. Mother's N	ame (First, Middle	Maiden Suman	re)	
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>	should be filed within and Mantel Hygiene. I marked other then umatic event, the Mantel Control of the Mantel	-	19a. Informant's Nar			~	Oh Mailine	Address (Street		Rural Route Numb		O	
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Baltimore,	semit. Pages 1 and 2 should be filed within Department of Health and Mantel Hygiene. Important: if Item 27 is marked other than mortant; or other traumatic event, the Mance.		20a. Method of Dispo		Removal from State	00000	tery, creme	tion (Neme of story or other pla	ce)	Date	20c. Location -	City or Town, State	
Ē	Pag nent int: 1			5 ☐ Other (Specif		1							
ä	permit. Page Department of Important: If any Injury or pnce.		21. Signature of Fun	eral Service Licer	Wade, Mir	7	22.1	Name end Addre	ss of Facility	1 (55 77	D 1.1	ore Street	
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			23a. Part . Enter the shock or heart	failure. List only	plications that caused one cause on each li	ne.	o not enter	the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,	Approximate Interval Bety	ween
	Physician					-	4		11			Onset and D	Jeath
4	/Medical Examiner		Immediate Ceuse (F disease or condition	inal		IN	(Inc.	i 07	line			54	בע'
	LAdillilei		resulting in death)		0.	Dyé to (or as	a conseque	ence of):		4			
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	death certificate be executed a attending physician end of for use as the buriel-transit	E	Sequentially list cond	ditions.	b	Due to (or as	e conseque	ence of):					
ó	6 CE -		Sequentially list conditions if any, leading to immorause. Enter Underly Ceuse (Disease or in	nediate ving		1/2	Sul	boat	1000-			140	
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o.	tha hed	Sign	Part II. Other eignific	ant conditions co	ontributing to death b	ut not resulting	in the und	erlying cause giv	en in Part I.	23b. Did	tobacco use cor	tribute to the cause o	f death?
٣.	law requiras thet the de as been signed by tha 2 should be datached	P.								10	Yes 2 No	3 ☐ Probably 4 ☐ U	Unknown
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sio	Attending or deeth. actor: After by the fune	Sat	2 Accident	investigation				M 1	Yes 2 □ No				
Division	or Attendate destable Director:	\$	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju- building, etc		farm, street	t, factory, office		28f. Location (S City or Tox	Street and Number	er or Rural Route Numb	ber,
	s after	Certification:			,	(,,		
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	To the Hospital or Attend within 24 hours after deet! To the Funeral Director: completaly filled in by the	edicai	(Check only 2 one)	☐ medical Exam	and menner ste	examination e	and/or inves	stigation, in my o	pinion, death occ	urred et the time,	date and place, a	nd due to the cause(s)	1
	within 2 To the comple	Σ	29b. Signature and lit	le of certifier	-17		-	29c. Licens			29d. Date signed	(Month, Day, Year)	
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		}	30. Name and addres	s of percon who	completed saves of d	eath (Non- Co-	\(Time 2	int\ a	7 - 7 0	11	pro a	7	
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DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1208 AM Harrison 2005 James 0 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care Old Randallstown Court If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□ F Hours 212-28-9451 Yrs Director Apr 23, 1930 Maryland Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show may injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2√ No Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Schnapers Drive #404 21133 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐XNo 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Herman Harrison Emma Gertrude McCabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Castor/sister 3411 Springhouse Circle Stone Mtn, GA 30087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. W. 22. Name and Address of Facility · Wade S State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 will 23a. Part1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atheosclerotic cardiovasc Years /Medical Due to (or as a consequence of): **Examiner** Diabetes mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): physician and s the burial-transit law requires that the death certificate be executed Hy pertention Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ficate has been sig r, page 2 should b 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Vascula certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ZYes 2 □ No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funerel D completely filled i 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 2005 n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of it Registrar's Signature 31. Date filed (Month, Day, Year) State 1 5 2005 Registrar

			for Stete Registrar	State of Marylar		artment of H			iene	23219
	Physici		1. Decedent's Name (First, Middle, Las	EY				2. Date of Deal Month	Day Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give Suburban Hosp	ital		4b. City, Town, or Bethes	sda	th	4c. County of Dea Montgome	ry
	Funeral Director		5. Social Security Number 217-44-4787 Usual Residence of Decedent	ex	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			thplace (State or Foreign bunity) shington DC
	se Maryland Ba-f show difficed at	ctor	10a. State 10b. County MD Wicomics		ty, Town or Lo	tsville				10d. Inside City Limits
	3a or 2	I Dire	10e. Street and Number 7425 Cemetery	y Avenue		10f. Zip Code	21850	1	0g. Citízen of What Co USA	
980	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Itams 23a or 28a-1 show ther, the Medical Exacinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (: in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whi Specify: Wh	te, etc.
21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2	ucation de completed) College (1-4or 5+)	(Give life.	dent's Usual Occupi kind of work done of DO NOT use retired	ation during most of wo	prking	16b. Kind of Business	/Industry unk
Maryland 2	2 should be filed withir and Mental Hygiene. Is markad other than aumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Ruby Frank Mart		CTE	FICAL		me (First, Middle, I	Maiden Sumame) Childress	
	1 and Health am 27 ther tr		19a. Informant's Name/Relationship (7 Christine M. Cen 20a. Method of Disposition	teno/daughter	6121		ne Drive	Mt. Airy	, Cîty or Town, State, MD 2177 20c. Location - City or	1
Baltimore,	permit. Pages Department of I Important: If its any injury or of		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify RO112 Ld Specify RO11	removal from State	1			d 655 W.	Baltimore	Street
THE PERSON NAMED IN	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or composition of healt failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a	th. Do not ent	ntimore, er the mode of dyin			est,	Approximate Interval Between Onset and Death (5 นอนาโฮ
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (issue or in it) that initiated events resulting in death) Last	CDue to (or as a consect	quence of):					
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ds, P.	uires that signed b	by	Part II. Other significant conditions o	ontributing to death but not re	sulting in the u	nderlying cause give	en in Part I.		pacco use contribute to	o the cause of death?
Vital Records,	10 22	e Completed	25. Was case referred to medical			11.			ry prior to ned? death? 2 No 1 ☐ Yes	utopsy findings available completion of cause of
of	ding Phys h. After this funeral di	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Novatural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injun Worl	er: 4 🗆 Nursing		ence 6 Other (Spe ow injury occurred	ocify)
Division	in bird	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office		28f. Location (Si City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in the Funeral Director of the Funeral Direc	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of my kn miner. On the basis of examin- and manner stated.	owledge, deat alion and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the course at the time, d	ause(s) and manner a are and place, and dur	s stated. e to the cause(s)
)	To th within To th	Me	29b. Signature and title of certifier	20		29c. Licenson			9d. Date signed (Moni	
			30. Name annuaddress of person who	completed cause of death (Ite		Print)	Benke	m jogo	July 5,2	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Pagistrar's Sign	ature	hade				

HARLEY, KAREN EUZARSETA 7/4/05 11:03 AN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 2005 JULY 10 11.24p M **JONES** ALICE NAOMI /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) DC 27/9 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1□M 20F 121-20-7976 Director Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at Md Frederick 1 Yes 2 No FREDERICR Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1421 21701 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) house keeper 1244 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be f and Mental F is marked of William Johnson Wickham ျှ osaben 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -averne 1001 Department of Health Important: If item 27 (dau Sobin errace MO 21701 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ■Burial 2 □ Cremation 3 □ Removal from State 16,2005 trepte kin alviren 4 Donation 5 □ Other (Specify) injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 110 WEST SOUTH any i · JUME FREDERIN mo 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear 1 slure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Dau Diecemania /Medical or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a considuence of): for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) the detached à signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? Hyperten fich certificate has Diease 2 | No Shoonic 1 Yes obtavetive 1 🗌 Yes 2 relmanay Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27 No Other: Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deat To the Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Chec 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) Shah Hivon, MD

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

P.O.

of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

homas

32. Registrar's Signature

			For State	State of Marylan		artment of Hea tificate of De				
	Physici	an	Registrar 1. Decedent's Name (First, Middle, Last)	Johnson		imodio or Di	Jan	2. Date of Death Month	Day Year	32 infig of poorty
	/Medic	al	William E. 4a. Facility Name (If not institution, give s		r.	4b. City, Town, or Lo	ocation of Death	July 1	L3, 2005 4c. County of Dear	2:37 A M
	Funeral		Alpine Beach Rd north of 5. Social Security Number 6. Sec. 187	7. Age (In yrs.	last birthday)		Under 24 Hrs.	8. Date of Birth (Month, Day,	Anne Aru	nde1 hplace (State or Foreign bunity)
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	nyland ihow		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
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Baltimore,	Pages ment of ent: If i		1 ☐ Burial 2 【XCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ematory or other place) ematory Inc	July 200		altimore,	Maryland
Balt	permit. Pages 1 en Depertment of Heal Importent: If item 2 any injury or other <u>once</u> .		21. Signature of Funeral Service License	Hallens)	Name and Address of 3111 Mount	tain Road	d. Pasade	ena. MD 21	Home, P.A. 122
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Division of	tending leath. tor: After the fune	Certification: To	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 7 - 13 - 05 28e. Place of Injury - At h building, etc. (Specif	28b. Time of Injury	28c. Injury at Work?	5 2 XNo	8d. Describe how	vinjury occurred Of Note Tuck Bet and Number or Ru	vehicle
L	Hospite 4 hours Funerel ely filled	edicai Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the time, restigation, in my opini	date and place, a	nd due to the cau	use(s) and manner as e and place, and due	stated. to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	- Pollo	e m	29c. License ni OCME	umber		d. Date signed (Mont.) July 13,	
	7		30 Name and address of person Ano con	mpleted cause of death (Item	п 23а) (Туре,	Print) 111 Per	nn Stree	t Balti	more, Mary	land 21201
es _i a	Sta Registr		31. Date filed (Month, Day, Year) 1 5	32. Registra's Signa	ature	Couls				

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	_		Registrar 1. Decedent's Name (First, Middle, Last)		Reg. 2. Date of Death	No. C U U J	3. Time of Death
	Physici		Phullis L. Jackson			Day Year 2005	07:35 PM
	/Medic Examin			or Location of Death	-411	4c. County of Death	
	_xaiiiii		University of Maryland Medical Center Balti	imore City	a	NIA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
	Director		220-10-0492 Trs. 91		Dec. 4,10	157 NI	aryland
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	Maryl f sho	ō	Maryland N/A Baltimore				1 Yes 2 No
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36	or it	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No		, , , , , , , , , , , , , , , , , , , ,	Specify: 7) [()
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	1 and 2 Health ar em 27 Is ther trau		20a. Method of Disposition 20b. Place of Disposition (Name of	OII ST.	Balto	Location - City or T	230
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Baltimore,	- 등 원 등		' 4 □ Donation 5 □ Other (Specify) 21. Signatyre of Funeral Service Licensee 22. Name and Addre	TOTAL !	203 B	alto. 1	ia.
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	Physician		shief, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a hemographic Stroke	2			Interval Between Onset and Death
	/Medical	100	disease or condition resulting in death) a. https://disease.com/d				
	Examiner		Sequentially list conditions, b.				
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<u>a</u>	ician: Th certificate rector, pag				1 ☐ Yes 2 🛣		2□ No
Division of Vital Records,		o Be	25. Was case referred to medical examiner? 1	26. Place of Death		6 Flother (0-1-1	The state of the s
o	문 는 F		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury		Bd. Describe how in	6 ☐Other (Speci njury occurred	ry)
0	r Attending er death. rector: After by the funer	atio		rk?]Yes 2□No			
<u>S</u>	r Atte er de recto by th	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	8f. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
	ital o irs aft ral Di		,				
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my of	me, date and place, ar opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as and place, and due t	stated. o the cause(s)
	thin 2 thin 2 the mplet	Med	one) and manner stated. 29b. Signature and title of certifier 2 29c. Licens			Date signed (Month,	
1	F 3 F 8			604		07/10/	
	(Ca)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			U + / 1 U /	2003
	(4)		22 S. Greene St. BALTIMORE, MD)			
	Sta	te	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature				
	Registi	ar	JUL 1 5 2005 Rome B. Amelia				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Joh orenc 2005 4b. City, Town, or Location of Death 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Homewood Bal timore N/A しなく If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Deys 213-36-6381 1□M 2 F Yrs. Maryland 67 Dec 16, 1937 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Baltimore** N/A Md 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3512 Woodland Ave. 21215 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: Specify. Black 3x Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy E. Kent Roger B. Kent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 1209 Cedarcroft Rd. Baltimore, Maryland 21239 Shawn Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 07/14/05 Landsdown, Md. 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Estep Brothers Funeral Service PA 1300 Eutaw Place Baltimore, Md 21217 Part . Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) ANOSIL ENCEPHALOPATHY UNICSOUN Due to (or as a consequence of) CEREBROYASCULAR ACCIDENT Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4V Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably DISORDER 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was en autopsy performed? Hypucholestrolema 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

certificete be executed

The law requires that the death

certificate hes

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Director

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Completed

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7 is marked other than "natural", or itams 23a or 28a-f sho treumatic avent, the Medical Exeminar must be notified at

12 should be filed within 72 hours efter on the Mentel Hygiene is marked other than "natural", or ital

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Baltimore, Maryland 21215-0020

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Examiner ettending physiclan end I for use es the burial-trenslt ed by the e To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funerel Diractor: After this certifics completely filled in by the funeral director, I

Physician/Medical ð Completed Be Certification: To

Medicai

State Registrar SE1ZURE

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manper of Death Natural 5 Pending investigation 2 Accident 3 Suicide

6 Could not be determined 4 Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Dete of Injury (Month, Day Year) 28b. Time of

28c. Injury et Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certific

29a. Certifier

D SALVJAMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 000 540 56

1600 WEST MT Royal Ave

DALJEET SALUJA 31. Date filed (Month, Day, Year)

MO 32. Registrar's Signature

2005



DHMH 16 Rev 6/95

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

		State of Maryland / Department of Health and Maryland / Department of Health Andrews / Department /		giene Reg. NØ: N A S	23221.
Physici /Medic		1. Decedent's Name (First, Middle, Last) DOROTHY KISER	2. Date of Dea	Day Year	3. Time of beatiff - ((AM) M
Examin		4a. Facility Name (If not institution, give street and number) No NTHWEST HOIP (TAL NAW) AUSTO	ると	4c. County of De	TIMME
Funeral Director		5. Social Security Number 217-01-1084 6. Sex 1 de la figure 1 de la figure 1 de la figure 24 Hrs. 86 yrs. 6. Sex 1 de la figure 24 Hrs. 7. Sex 1 de la figur	8. Date of Birt (Month, Day Dec. 22	v. Year) _ (ithplace (State or Foreign Country) lassachusetts
aryland show	J.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Reisterstown			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the M 28e-f	Directo	10e. Street and Number 10f. Zip Code		10g. Citizen of What 0	Country?
h with 23e or		913 Chromine Rd. 21136		U.S.A.	
within 72 hours after death with the Maryland liene. iene. r than "netural", or items 23e or 28e-f show lie Medical Examinat must be motified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Specify: 1 Yes 2 No Specify:	pecify Yes or No Rican, etc.)	Black, Wh	nerican Indian, lite, etc. Thite
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iii. Pages 1 and 2 should be iii. Pages 1 and 2 should be arment of Health and Menta ortent: If item 27 is marked injury or other treumatic e.	2	19a. Informant's Name/Relationship (Type, Print) Lee Ensor - Friend 19b. Mailing Address (Street and Number or Ru 1019 Chromine Rd., Re:			
altimore, IN mit. Pages 1 and 2 partment of Health portent: If item 27 i		20a. Method of Disposition 1 Disposition 20b. Place of Disposition (Name of cametary, crematory or other place) Loudon Park Cem. July 1.	Date 7	20c. Location - City of Baltimore,	
permit. Pag permit. Pag Department Importent: I any injury c		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Echardt Funeral L1605 Reisterstow	Chapel, n kd., C	P.A. Wings Mill	21117 .s, Md.
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S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	- 1		

		4	For	State of Maryland	•			lental Hyg	iene	200=	
			State Registrar		Cen	tificate of	Death		g. No. 🗸	2005	23225
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	/Medic	al -	MARY 4a. Fecility Name (If not institution, give s		001	4h Cihi Town	or Location of Death	JULY	10th	2005 ounty of Death	01:10 AM
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	Funeral		5. Social Security Number 6. Sex		ast birthday)	If Under 1 Yea		8. Date of Birth	V	9. Birthp	lace (State or Foreign
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	28e-1	Director	10e. Street and Number		De!	10f. Zip Code		11	Da. Citize	en of What Cour	ntry?
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	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V		Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No-	14	Race - Americ	
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/lar	should be and Mental s marked o umatic eve	To E	Unlace Hai	nmond			Elliot	+ Mai	, 1	ucla	stiar
Maryland 21215-0036	C1 10 - 15		19a Informant's Name/Relationship (Ty		19b. Mailin	g Address (Stre	et and Number or Ru	ral Route Number	City or	Town, State, Zip	Code)
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Baltimore,	Pages nent of h int: If its iry or of		20a. Nethod of Disposition 1 Burial 2 Cremation 3 F		emetery, crem	atory or other p			-	*	- 110
亞	artmer prtent injury	i	 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature ≠ Funeral/Service/Licens 	INOI	e 10/10	Name and Ado	Iress of Facility	3.05 10PORT	DATE	TIMOS	ST ALU /
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Vital		e Co	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes	2 No	1 🗆 Yes	2 No
>		0 8	examiner?	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA	Othor	ome 5 Reside		Other (Specif	(v)
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	e Hospiter 24 hours e Funerer letely filled	edical	(Check only one)	iner: On the basis of examina and manner stated.	tion and/or in	vestigation, in m	y opinion, death occu	rred at the time, o	ate and	place, and due to	o the cause(s)
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	4		Nonna m.	Everely m.	٥.	D	054739		JULY	10Th 2	005
9			30. Name and address of person who c								
-			2434 W. Bei	e dere Avenue	, Ba	IKMOVE	e Maryl	and 2	1215	*	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	Some	63					

DHMH 17 Rev 1/2001

			For State	State	of Marylar		ırtmen <i>tificat</i> ı			ınd M		giene Reg. No	201	nc	22206
			Registrar 1. Decedent's Name (First, Middle, Las	t) .	3		imoati	0 0, 2	Joann		2. Date of Dea		201		3. Time of Death
	Physicia	an	THUN	11.1	000						Month	Da		Year	/ · / E TO 6 M
	/Medic		4a. Fecility Name (If not institution, give	F17	I TVC		4h City	Town or	Location o		June 27	_	005 County o	of Death	4:45 PM M
	Examin	er	is an account of a second							Doon			ueen		010
			Corsica Hills 1 5. Social Security Number 6. Se		7. Age (In yrs.	last birthday)	If Under	trev 1 Year	If Under 2	24 Hrs.	8. Date of Birt	h			place (State or Foreign
	Funeral Director		1	M 2∏F	87	Yrs.	Months	Days	Hours	Min.	Feb 24	y, Year) 19	18	Cow	yland
			219-01-6588 Usual Residence of Decedent		- 07										
	yland Now		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	10d. Inside City Limits
	Mar Field	to	MD Oueen A	nne's		Centr	evil1	.e							1 Yes 2 No
	1 28 r	Director	10e. Street and Number				10f. Zip					10g. Cit	tizen of W	hat Cou	ntry?
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	deat	Funeral	11. Marital Status		cedent Ever in U	J.S. 13. \	Vas Deced	dent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)			- Americ	can Indian,
٥	or its	교	1 ☐ Never Married 2 ☐ Married		2X No		1 🗆 Yes		Specify:		, , , , , , ,		Specify:		
3	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or itema 23a or 28e-f show event, it a Moultal Examinar must be notified at	Completed by	3 Widowed 4 □ Divorced	Year or	Dates:										
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Maryland 21215-0036	d la b	Be	John Weathersti	en							ose Lac			-,	
Ë	should be ind Mental i marked o umatic eve	5	19a. Informant's Name/Relationship (1			19b Mailir	no Address	(Street a	and Numbe		I Route Numbe			State Zir	Code)
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Baltimore,	Pages net of int: If it		1 Burial 2 Cremation 3		n State	cemetery, crer	natory or o	other place	9)					,	
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			shock, of heart failure. List only tmmediate Cause (Final	one cause on	each line.	Ω									Interval Between Onset and Death
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	the att	Sicle	in the past 12 months?		gnant at time of		Other (sp						Mon	าเก	Day Year
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Division of Vital Records,	or Atter de Directe	Certification:	3 Suicide 6 Could not be determined	289. Pla	ce of fnjury - At Iding, etc. (Spec	home, farm, st	reet, factor	y, office			28f. Location (City or To			er or Rur	al Route Number,
0	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer			ļ											
	Hosp 4 hou Fune ely fil	cal	29a. Certifier 1 Check only 2 Medical Example 1	niner: On the	basis of examin	nowledge, deat nation and/or in	h occurred vestigation	at the time, in my of	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s date an	s) and mai nd place, a	nner as a	stated. to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one)	and ma	anner stated.	Her les		c. License							Day, Year)
1	with To	-	29b. Signature and title of certifier	12241			29			>1			-		
7			1277	\\\\				9	120	56		6	1751	() W	<i>)</i>)
			30. Name and address of person who	completed ca	use of death (Ite		Print)	. 0	V1	, 0	م بلره	M A) /.	1 10	
		210	31. Date filed (Month, Day, Year)	36	Registrar's Sign	- 0	, 0, 0,	17	ال	u	Do Ne	·CD	04/(419	
	St Regist	ate rar	31. Date filed (Month, Day, Year) 20	UD B	Dur 1	5 April	SALL								

		For State Registrer	ate of Maryland / D	epartment of H Certificate of		ental Hygie		
Physici /Medio		1. Decedent's Name (First, Middle, Last) Harry F. Koenig				2. Date of Death Month July 13,	Day 20 Que	32 ing of perm 7
Examir		4a. Facility Name (If not institution, give street Gilchrist Center		Towson			4c. County of Dea	re
Funeral Director		5. Social Security Number 220-05-4282 Usual Residence of Decedent	7. Age (In yrs. last birth	(rs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You March 7,	ear) Co	thplace (State or Foreign ountry) aryland
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or thems 23s or 28s-f show sumatic event. Its Medical Executations to neither all	rector	10a. State 10b. County Maryland Baltimore 10e. Street and Number	10c. City, Town			100	. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
eath with	Funeral Director	137 Warwick Drive	/as Decedent Ever in U.S.	21093			USA 14. Race - Ame	
ours after d	ρ	1 ☐ Never Married 2 ☑ Married 1	med Forces? ☑ Yes 2 □ No WWII Yes, Give ear or Dates:	If Yes, specify Cubi	Specify:	Rican, etc.)	Black, Whit	
portition of signal of the Maryla product of the Maryla permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygeine. Production: If Itam 27 Is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event. If a Madical Exactlination once.	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)	npleted) college (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of worki d)	ng	b. Kind of Business	·
ild be filed illohal Hygierked other	To Be Co	17. Father's Name (First, Middle, Last) Edward Koenic		<u>ectrical In</u>		(First, Middle, Mai	U.S. Navy ^{iden Sumame)} ossman	
ind 2 shou alth and M 27 is mar	-	19a. Informant's Name/Relationship (Type, P Dennis Koenig/ son	<i>Print)</i> 19b.	Mailing Address (Street 074 Barrens	and Number or Rura	l Route Number, C	ity or Town, State, 2	
Pages 1 and of the next of Herman II It It It It It It It It It It It It		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removed 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of cemetery	Disposition (Name of r, crematory or other place ood Cemeter	ce)	ate 200	c. Location - City or Kingsley,	Town, State
permit. Departitingorts any inji		21. Signature of Funeral Service Licensee Ste	ephen Coster	22. Name and Addre	Road, Tov			Home, Inc. 04
Physician /Medical		2. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	ns that caused the death. Do no use on each line. Due to (or a) a consequence o	er o			•	Approximate Interval Between Onset and Death
icate be executed physician and suppressions the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Malianan+ Due to (or as a consequence of	Mesor	thelio	mA		
	Physician/Medi	in the past 12 months?	yes, outcome of pregnancy □Live birth 2□Fetal death □Pregnant at time of death □Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	1		23d. Date of del Month	ivery Day Year
w requires that the table of the table of the table of the table of the table of the table of the table of the table of the table of the table of the table of the table of the table of the table of the table of the table of the table of the table of the table of t	eted by Ph	Part II. Other significant conditions contribu	ting to death but not resulting in	the underlying cause giv	ren in Part I.	10	cco use contribute to	the cause of death?
25 8	Complet					24a. Was an autopsy performed	d? prior to death?	itopsy findings available completion of cause of
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filted in by the funeral director, page 2 should be detached for use as	To Be	1 Natural 5 ☐ Pending	ta. Date of Injury 28b. Ti	me of 28c. Injur	y at 2	(Check only one) ne 5 Residence 28d. Describe how		city) hospice
l or Attend after death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28	Be. Place of Injury - At home, fare building, etc. (Specify)		Yes 2 □No	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
ne Hospita 24 hours ne Funeral	edical C	(Check only 1 2 Medical Examiner: (n: To the best of my knowledge, On the basis of examination and and manner stated.	death occurred at the tir /or investigation, in my o	me, date and place, a pinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the To the Comp	Me	29b. Signature and title of certifier)	29c. Licens	8303	29d.	Date signed (Month	h, Day, Year)
61		Agran CHARLES	ted cause of death (Item 23a) (T	Type, Print) 1. Charles	S+ T	NOW	mp 212	04
Sta Regist	_	31. Date filed (Month, Day, Year) JUL 1 5 2005	22. Registrar's Signature	code				,

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	•	•	ent of H		/lental H	ygier Reg. N	000	22220
			1. Decedent's Name (First, Middle, Last)						2. Date of I		ay Year	3. Time of Beatle
	Physici /Medic		William H. Kenn	edy, Sr.					July		2005	12:15P M
	Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. C	City, Town, or	Location of Death		4	c. County of Deatl	h
			203 England Terr 5. Social Security Number 6. Sex		(In yrs. last birth		Rockvil	le If Under 24 Hrs.	8. Date of I	Didh	Montgome	
	Funeral Director		5. Social Security Number 6. Sex 12	M 2□F 7. Age			ths Days	Hours Min.	(Month,	Day, Yea	r) 9. Birti	nplace (State or Foreign untry)
			Usual Residence of Decedent		07				reb.	10,	1930 was	hington, DC
	how		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Ba-f	cto	Maryland Montgomer	y	Rockvil	7						1X Yes 2 No
	ith with the Marylar 23s or 28s-f ehow	Funeral Director	10e. Street and Number			10f.	. Zip Code			10g. C	Citizen of What Co	untry?
	eath v	eral	203 England Terrac	e 2. Was Decedent E	ver in LLS	13 Was D	20850) spanic Origin? (Sp	acifu Vas or		ited Sta	
10	iter d	Fun	1 Never Married 2 Married	Armed Forces?		If Yes,	specify Cuba	n, Mexican, Puerto	Rican, etc.)	40-	Black, White	
036	urs aft	by	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates:		1 □ Ye	s 2∏ No	Specify:			Specify: Wh	ite
5-0	72 hours "natural",	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. [Decedent's t	Usual Occupa	ation	cina .	16b.	Kind of Business/I	
2	ithin ne.	ηpie	Elementary/Secondary (0-12)	College (1-4or 5-	·)			furing most of work)				
2	be filed within ital Hyglene. Id other than event, Itte My		11 17. Father's Name (First, Middle, Last)		Po	lice	Office	18. Mother's Nam	o /Fimt Midd			ol Police
anc	ntal Hed of	o Be								iie, maiue	an Sumame)	
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If Item 27 ie marked other than "natural", or Items 23a or 28a-f ehoweny injury or other traumatic event, Itte Medical Examiner must be notified at once.	ĭ	Fred C. Kennedy 19a. Informant's Name/Relationship (Type	ne, Print)	19b.	Mailing Add	ress (Street a	Ruth De		nber, City	or Town, State, Z	ip Code)
N N	and 2 (William H. Kenned	v. Jr./So			.00				, Maryla	
altimore,	of Hee	i	20a. Method of Disposition		20b. Place of I	Disposition i			Date		Location - City or 1	
Ĕ	Peges nent of I int: If It		1 ☐ Burial 2 🛣 Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Montgon Cremato	nery	Inc	200	05	Be	thesda,	Marvland
alti	permit. Departn Importa eny Inju		21. Signature of neral Service Lidense	ө	OLCINOLO	22. Nam	e and Addres	s of Facility Ro	bert A	. Pu	mphrey F	uneral Home/ venue
_	82558		1 Juil Ela	m,	M00803	Rocky	ille,	Maryland	2085	0-28	05	venue
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused e cause on each lin	the death. Do no	ot enter the	mode of dying	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Acute	Arrhythm	nia						Instant
	/Medical Examiner		resulting in death)		consequence of							
		4	Sequentially list conditions, if any, leading to immediate		ry Arter		ease					Years
	ited I Insit	Examiner	Cause (Disease or injury		ipidemia							Years
Ć.	be executed sicien and burial-transit	Exa	that initiated events resulting in death) Last		consequence of							Italb
8760,	ate be hysicie the bur	dicai	d									
9	0 0.	Med	IF FEMALE:									
SX SX	eath certiff ettending for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 ☐ Fetal death		ic pregnancy				23d. Date of deli-	very Day Year
20.0	the e	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death	5 🗌 Other	(specify)			- 1	Month	buy rour
D a.	that the di ad by the detached		Part II. Other significant conditions con	tnbuting to death bu	t not resulting in	the undertvi	ng cause give	en in Part I.	23e. Die	d tobacco	use contribute to	the cause of death?
\prec \prec	uires tha signed Id be de	Completed by	Pulmonary Fibrosi						1 5	Ž Yes	2 □ No 3 □ Pro	babiy 4 Dunknown
A CK	w requir been si should	ete							24a. W	as an	24b. Were aut	topsy findings available
Re Re	The law cate has page 2 t	ошо	Tobacco Abuse, Hi	Ru prood	rressure				au	topsy rformed?	prior to c death?	ompletion of cause of
ital	iclan: Th certificate rector, pag	0	25. Was case referred to medical					26. Place of Deal	1 ☐ Yes		lo 1 Tes	2□ No
0>	S .5 5	To B	examiner? 1 X Yes 2 ☐ No	ospital: 1 Inpatier	nt 2 ER/Outp	patient 3	DOA Othe				6 ☐Other (Spec	ıfy)
Z u	tending Physicath. tor: After this the funeral di		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Ti	me of jury	28c. Injury Work	at	28d. Describ			
$\chi + \chi \chi$ ivision	Attending r death.	catic	2 Accident investigation			М	1 🗆 1	res 2 □ No				
\rac{\varphi}{\varphi}\varphi}		Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farr . <i>(Specify)</i>	n, street, fac	ctory, office		28f. Location City or 7	(Street a	and Number or Rui te)	ral Route Number,
	Hospital or 14 hours efte Funeral Dir tely filled in	Ce	200 Continue 1 X Continue Phys	ician. T. the beat	4 ledd							
	Hos 24 ho Fun	Medicai	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examin	er: On the basis of and manner state	examination and	death occur or investiga	tion, in my op	e, date and place, pinion, death occur	and due to tr red at the tim	e, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier				29c. License	number		29d. D	ate signed (Month	, Dey, Year)
	41		Marked &	COLA			1 ממת	0493		т	1 12 12 2/	20.5
	10 1		30. Name and address of person who con	mpleted cause of de	ath (Item 23a) (1	ype, Print)	וטטע	U473		Ju	1y 13, 20	70,7
_	10		John S. Saia, M.D	1201 S	even Loc	ks Ro	ad, #2	02, Rock	ville,	Mar	yland 20	0854
	Sta Registi		31. Date filed (Month, gay Year 5 2	005 32. R distra	r's Signature	600	le					
	negisti	ul			-	-						

		For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of H	lealth and		ie 2e() () 5	23229
Physicia /Medica Examine	1	1. Decedent's Name (First, Middle, L DONAL 4a. Facility Name (If not institution, gi	Henry !	KISS	4b. City, Town, or	Location of Deat		Day Year 8 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	- 100
Funeral Director		5. Social Security Number 6.	Sex 7. Age (In yrs. 1 ₹ M 2 ☐ F 74		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	9. Bi 9. Bi	rthplace (State or Foreign ountry) unk
th the Maryland or 28a-f show a notified at	Director	10a. State 10b. County MD Anne 10e. Street and Number	Arundel	ty. Town or Lo			1	0g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☑ No ountry?
after death v	by Funeral D	423 Cresswell 11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Road 12. Was Decedent Ever in U Amned Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2√ No	21225 ispanic Origin? (Sun, Mexican, Puen	ipecify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	erican Indian,
A 1X 13-0030 d within 72 hours af giene. The Medical Exem	Completed t	Specify only highest g Elementary/Secondary (0-12)	Education	(Give	lent's Usual Occupa kind of work done of OO NOT use retired	during most of wo	rking unk	16b. Kind of Business	
naryland 2 2 should be filed v and Mental Hygic is marked other raumatic event, it	To Be C	17. Father's Name (First, Middle, Las		19b Mailir			me (First, Middle, M	Maiden Sumame) , City or Town, State,	unk Zip Code) unk
MOCE, Ma Pages 1 and 2 s hent of Health an nor: M item 27 is nor other trau		Anne Arundel Poli 20a. Method of Disposition 1 Burial 2 Cremation 3	_ce Dept □Removal from State	Place of Dispo	sition (Name of natory or other plac			20c. Location - City of	
Baltimo permit. Pages Department of Importent: If is any injury or once.		*4 □ Donation 5 ☑ Other (Spec 21. Signature of Funeral Service) ic Ronald S	Wade Directo	Ba	ltimore,	MD 212	01	Baltimore	
ate be hysicia he bur	dical Examiner	3a. Part1 Enter the disease, or a shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Esquantially list ear dillors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	y one caus on each line.	quence of):	rofic	Henry		EAS-C	Approximate Interval Between Onset and Death
the death cert the attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3 □	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
law requires that as been signed by 2 should be deta	۵	Part II. Other significant conditions	contributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.		pacco use contribute t	o the cause of death?
The lay ate has page 2	e Completed	25. Was case referred to medical				26 Place of De	24a. Was a autops perform 1 Yes 2	y prior to death? 2 Stylo 1 □ Ye.	utopsy findings available completion of cause of s 2 No
# # # #	atlon; To B	examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injun Work	er: 4 Nursing H	lome 5	<u> </u>	ecify)
DIVISION pitel or Attending ours after death. ours after death. illed in by the func	Certification;	3 Suicide 6 Could not determine	building, etc. (Speci	ify)			City or Towr		
Fo the Hos within 24 ho Fo the Functional Completely f	Medical	29a. Certifier (Check only one) 1 Certifying F 2 Medical Extended Property one)	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	ation and/or in	vestigation, in my op	pinion, death occu	urred at the time, da	ause(s) and manner a ate and place, and du 9d. Date signed (Mon	e to the cause(s)
7.50		30. Name and address of person wh		m 23a) (Type,	Print)	20060	54	2103	5
Stat Registra		31. Date filed (Month, Day, Year) JUL 1 5 20	32. Registrar's Sign	ature	695 W	1m	erica	2103	5 5

HERBERT LOGAN 05-04640 RKD

			1 - For State Registrar	State of Marylan	•	nt of Health and te of Death		iene	000	_
1	Physici /Medic		1. Decedent's Name (First, Middle, Last) Herbert	LOGAN	7		2. Date of Death Month JULY	Day 10,	2005	3.2 imgo 2 eath 0 7:00A. M
	Examin	_	4a. Facility Name (If not institution, give s 2800 JEFFERSON STRE			y, Town, or Location of Deat LTIMORE			ity of Death	
*	Funeral Director			M 2□F 7. Age (In yrs.	last birthday) If Und Month	er 1 Year If Under 24 Hrs s Days Hours Min.		F3	9. Birthp Count May	lace (State or Foreign htry)
	Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location	<i>c</i> -			1	0d. Inside City Limits 1
	or 28a-	Director	10e. Street and Number		Utimo 10f. 2	Lip Code	10	0g. Citizen o	f What Cour	ntry?
	s 23a	rai	2918 Kosalii	2. Was Decedent Ever in U	C 13 Was Day	21215 edent of Hispanic Origin? (S	Sanadi Van as Na	U	SA ace - Americ	an Indian
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show simportent: If item 27 is marked other then "natural", or items 23a or 28a-f show simply injury or other treumatic event, I'm Medical Examinal must be notified at an ODGs.	by Funerai	1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, sp	pecify Cuban, Mexican, Puer	to Rican, etc.)		tack, White,	
5-0036	72 ho	eted	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Us	vork done during most of wo	orking	16b. Kind of	Business/înc	dustry
d 2121	filed within Hygiene. other then out, the Mac	e Completed	Elementary/Spotondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Machi	we Open	z-for (me (First, Middle, A	916S Maiden Sum	w d	Holmes
/lan	should be nd Mental marked o	To Be	Henry Wes.	+		Dom	Hky 1	Log	AN	
Maryland	12 sho h and l 7 ls ma treuma		19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailing Addre	ss (Street and Number or R	ural Route Number.	City or Tow	n, State, Zip	Code)
	ss 1 and 2 of Health Itam 27 I		20a. Method of Disposition		Place of Disposition (A	lame of	Date	20c. Location	n - City or To	own, State
Baltimore,	Pages ment of ent: If it ury or o		Deurial 2 ☐ Cremation 3 ☐ Riv 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	WHSVILL	Cemetery -	1/15/05	rown	SVILLE	OM,
Balt	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service License	L	Vare	ghin Cor	ene Fr	eve	als	evices
			23a. Part1. Enter the disease, or complic	cations that caused the deat	h. Do not enter the m	ode of dying tuch as cardia	c or respiratory arre	9.140 . est,	MD	Approximate Interval Between
80	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	HYPERTENSIVE	ARTERTOSCI	EROTIC CARDI	OVASCIII.AR	DISE	ASE	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conseq		MACTIC OMAZI	OVADOCIAN		3.010	
	P	Jer	Sequentially list conditions bird any, leading to immediate	Due to (or as a conseq	uence of):					
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.O. Box	ie death certifica the attending ph hed for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Ectopic				Date of delive Month	Day Year
۵,	n requires that the de been signed by the should be detached		Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tob	acco use co	ontribute to th	ne cause of death?
rds	equires en sign ould be	ed by					1 □ Ye	s 2 No	3 Prob	ably 4 Unknown
I Records,	The lay	Completed					24a. Was an autops perform		death?	psy findings available mpletion of cause of
of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othor	ath (Check only on			COTATA
of	Phys this al di	n: To	27. Manner of Death	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of	DOA 4 Nursing 1 28c. Injury at Work?	Home 5 Reside			w SCENE
ion	Attending Isr death.	atlo	1 Natural 5 Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No				
Division	To the Hospitel or Attendi within 24 hours efter death. To the Funaral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fact (y)	ory, office	28f. Location (Sti City or Town		nber or Rura	l Route Number,
	Hosp 24 hou Funal	Medical	29a. Certifier 1 ☐ Certifying Phys (Check out) 2 ☑ Medical Examin	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death occum ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and ate and plac	manner as s e, and due to	tated. o the cause(s)
	To the within To the comple	Me	29b Signature and title of certifie	and married states.		29c. License number	25	9d. Date sig	ned (Month,	Day, Year)
	4		Y / Certen	40)		OCME	J	ULY 10), 200	5
6	7		30. Name and address of person who co J.LARON LOCKE MD.	mpleted cause of death (Iter		.1 Penn Stree	t Baltim	ore, l	aryla:	nd 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature grands					

amend item#5, perFh, 6845. //25/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. 2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 9:53 PM LIPM AN JULY 12 2005 GLENN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** n/a BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Oct. 18, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1√ M 2□ F Maryland 220-62-4292 Yrs 51 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b Count permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itama 23a or 28a-f show any injury or other fraumatic event, the Modical Examics must be notified #1 once. 1 ☐ Yes 2 X No Baltimore Directo MD Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8523 Pleasant Plains Road 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Herbert A. Lipman Charlotte Kain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1159 Old Manchester Road Westminster, MD. Inez Lipman Richardson/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Grdn. 07/16/2005 Timonium, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signatur of Funeral Service Licensee Stephen Coster 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 1044 CARDIAC ARREST /Medical Due to (or as a consequence of) **Examiner** RIGHT HEART FAILURE IDAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed PHLMONARY EMBOLUS IDAY Due to (or as a consequence of): Box 68760. DAY INTRAVASCULAR COAGULATION. DISSEMINATED attending ph I for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. RIGHT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼Unknown RENAL CANCER Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page performed certificate 2 No 1 Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 1 Inpatient 3 DOA 2 After this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 - Homicide filled 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of C , ND RES - 000 2005 JULY 12 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

DHMH 17 Rev 1/2001

State

Registrar

WILLIAM R. BURNS

5 2005

31. Date filed (Month, Day, Year)

BALTIMORE, MARYLAND

21287

600 NORTH WOLFE STREET

Registrar's Signature

			1 - For Stete Registrer	State of N	/larylan		artment rtificate			ind Me	_	giene Reg. Nocy	חחב	2222
	Physici /Medic		Decedent's Name (First, Middle, La Mary Elizabeth I	,							2. Date of De Month July	Day 09	2005	7.3.2 A M
	Examin		4a. Facility Name (If not institution, gir		r)		4b. City,	Town, or	Location of	f Death	-		County of Death	1
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	Funeral Director		215-34-6595	Sex 7. A 1 □ M 2 X F	Age (In yrs.	last birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 03/28/	1915	Coi	pplace (State or Foreign intry) Yland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
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	or 284	Director	10e. Street and Number				10f. Zip					10g. Citiza	en of What Cor	untry?
	ath wi	rai	100 Revolution S					078				USA		
	items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Force 1 \(\text{Yes} \) 2	s?	i.s. 13.	Was Deced If Yes, spec	lent of Histify Cubar	spanic Orig n, Mexican,	in? (Spec , Puerto R	cify Yes or No lican, etc.))- 1	 Race - Amer Black, White 	
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9-0	72 hours after deeth with the Maryland natural', or items 23a or 28a-1 show diesi Execitive court out the natified at		15. Decedent's E (Specify only highest gi	ducation		16a. Dece	dent's Usua kind of wor	I Occupa	ition	of workin	2	16b, Kin	d of Business/I	ndustry
21	within 7 iene.	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT us	e retired,)	OF WORKE	g			
12	e filed w Il Hygier other th		7th 17. Father's Name (First, Middle, Las	t1		Hom	emake	er	18 Mother	r's Name	(First, Middle		me	
anc	d be fi	o Be	George Anderso								eckman		ourname)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-1 show other traumatic event, Ire Medical Exe. in or item 21 be mailified at	2	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a					Town, State, Z	ip Code)
Ĭ	and 2 ealth a m 27 is		Eva Bell- Daugh	iter		P.O.	Box	258	4, B	ande	ra, T>	78	003	
ore,			20a. Method of Disposition 1	Removal from Stat	20b. F	Place of Dispo cemetery, crei	sition (Nam natory or of	ne of ther place	9)	Da	ite	20c. Loc	ation - City or 1	Town, State
Ë	Pag iment tant: I		`4 □Donation 5 □Other (Spec		Du	blin St				7/12/			in, MD	
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Lice	ensee	' aO		Name and litche	d Addres	s of Facility	Fune	ral Ho	me,	P.A.	36D 240T0
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	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each a Due to (or a	i line.	Resp				,			ubelis	
	Examiner	10	Sequentially list conditions,	b. Due to (or a		Cong		-						2 days
\K	and transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		14A	ialf	ibr	Mat	on-l	new on	set		Idays
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical E	l	Due to (or a	as a consec	, delice (1).			<u></u>					
Box 6	leath certific attending pl	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon			∃Ectopic pro	egnancy			·············	23	3d. Date of deli	•
О	that the dealed by the att	ysici	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant 9☐ Unknown	at time of o		Other (sp						Month	Day Year
S, P	requires that the een signed by th hould be detache	by Pr	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying ca	ause give	en in Part I.		23e. Did 1	tobacco us	e contribute to	the cause of death?
rds	w requires been sign should be										1 🗆	Yes 2□	No 3□Pro	bably 4 Chiknown
Record	The law te has b age 2 st	ompleted							-		24a. Was auto perfo 1 \(\text{Yes}		prior to c death?	topsy findings available ompletion of cause of
Vital R	ician: T	e C	25. Was case referred to medical						26. Place	of Death	(Check only	-		
of V	di is	To B	examiner? 1 Yes 2 No	Hospital:		ER/Outpatier			4 Nul	rsing Hom	ne 5 ☐ Resi	dence 6	Other (Spec	eify)
	fter ne	iuo	27. Manner of Death 1 Natural 5 ☐ Pending		njury Da <i>y</i> Year)	28b. Time o Injury		8c. Injury Work	·?		8d. Describe	how injury	occurred	
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Di∨	after Direct	ertif	4 ☐ Homicide determine	building,	etc. (Speci	fy)	oot, lactory	, omoo			City or To	wn, State)		
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	To the within To the complex c	Me	29b. Signature and title of certifier	1)			29c	License	number				signed (Month	
	/		Tuken 19	Humans	-2	ט		Ho	054	439		7	تاع ۹،	2005
	5		30. Name and address of person who Viuceut A Gim	completed cause of	f death (Ite	m 23a) (Type,	Print)	RD	1 2e	5 7	Bel Air		0 2101	
	Sta Regist		31. Date filed (Month, Dav. Year)			ay Ap								

Junney, Mary 7/9/05 @ 0752

State of Maryland / Department of Health and Mental Hygiene											
			State Registrar		Certifica	te of Death	Reg. I	~2005 23233			
	Physici		1. Decedent's Name (First, Middle, Last) ATTIE	LAB	00			Dayth 2007 2:30 p. M			
	/Medic Examin		4a. Facility Name (If not institution, give s	reet and number)	4b. Cit	y, Town, or Location of De	eath .	4c. County of Death			
			Northwest k	laspital	R		J.A	1601 timore			
	Funeral Director		5. Social Security Number 6. Sex 10	7. Age (In yrs.)	Yrs. Month		in. 8. Date of Birth	9. Birthplace (State or Foreign Country)			
	D		Usual Residence of Decedent 10a. State 10b. County	, , , , , ,							
	Aaryla f shov	ō	11	nore	y, Town or Location	more		10d. Inside City Limits 1 ☐ Yes 2 ☑ 40			
	ilied within 72 hours after death with the Maryland Hyglene. thar than "natural", or Items 23a or 28a-f show that the Medical Eraminal must be molified at	Funeral Director	10e. Street and Number	1107 C		Zip Code	10g. (Citizen of What Country?			
	ath wit	rai D	3402 Janvale	e Rd		21244		USA			
	ter de	-une	11. Marital Status 1 Never Married 2 Married	 Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 Mo 	S. 13. Was Dec	cedent of Hispanic Origin? becify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.			
21215-0036	ral', or	þ	3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: Black			
15-0	"natu	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Us (Give kind of v life. DO NOT	work done during most of	working 1sb	Kind of Business/Industry			
212	withir iene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Insura	// 1	ust 5	ocial Security			
	be filed ital Hyg id otha evant,	Be C	17. Father's Name (First, Middle, Last)	_ 1.1_			lame (First, Middle Maid	en Sumame)			
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ore,	of Health of Health litem 27 r othar tr	ľ	20a. Method of Disposition 1 Agurial 2 Cremation 3 Re	20b. P	lace of Disposition (A emetery, crematory of	lame of rother place)		Location - City or Town, State			
3altimore,	. Pages tment of t tant: If ite		`4 □Donation 5 □ Other (Specify)	Ar	butus	7	16/05 B	altimore, MD			
Bai	permit. Page Department of Important: If any injury or once.		2 Sonal re of Funeral Service License	• • 0 •	22. Va.	and Address of Facility	ene Funer	al Services			
	K		23a. Part1. Ever the disease, or complic	ations that caused the death	n. Do not enter the m	ode of dying, such as card		Hown, MD 21133 Approximate			
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68760,	ficate physics the b	edicai	d.								
Вох	death certific attending p	M/W	23b. was decedent pregnant	c. If yes, outcome of pregna		pregnancy		23d. Date of delivery			
	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of de				Month Day Year			
P.0	that the		Part II. Dther significant conditions conf	ributing to death but not resi	ulting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?			
Records,	quires in sign	ed by					1 🗆 Yes	2 □No 3 □ Probably 4 □Unknown			
oce	law requir as been si 2 should	Completed					24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
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Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital: 1 (2 Impatient 2	FR/Out-stiest OF	Othor	Death (Check only one)	2 (20)			
of	- c	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 [[28b. Time of Injury	28c. Injury at Work?	Home 5 Residence 28d. Describe how in				
sior	Attanding r death. ector: Atter by the fune	catio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(month, buy rous)	M	1 Yes 2 No					
Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, facto	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)			
	To the Hospital or Attand within 24 hours after death To tha Funeral Director: completely filled in by the	ai C	29a. Certifier 1 Certifying Phys	cian: To the best of my kno	wiedge, death occurre	ed at the time, date and pla	ice, and due to the cause	(s) and manner as stated.			
	the Ho nin 24 tha Fu	Medical	one)	er: On the basis of examina and manner stated.				and place, and due to the cause(s)			
	To To Con	2	29b. Signature and title of certifier	Tan MD		9c. License number DS4288		Truly (6th 2005			
	h		30. Name and address of person who cor	npleted cause of death (Item	1 23a) (Type, Print)	US 4288 uttives 1408	0.0/	J 10,000			
_	5		Komowany I	Kangarag.		utines Ito	met com	9			
	Sta Registi	_	31. Date filed (Month, Day, Year) 2005	2. Registrar's Signa	Joseph South						

			State of Ma	aryland / De	partment of H	leaith and M	-	_	
Physicia	an	For State Registrar 1. Decedent's Name (First, Middle, I		binski	ertificate of	Death	2. Date of Deat Month	Day Year	2 Tale 2 Birt
/Medic	al	Walter		pinsici		1 222 (5 4	7	12 200 4c. County of Dea	
Examine	er	4a. Facility Name (If not institution, g Johns Hopkins Ba		al Center	Baltime	r Location of Death		Baltimo	
Funeral Director		5. Social Security Number 6 217-38-4669		e (In yrs. last birthda 62 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 1	9. Bi 3,1942 Ma	rthplece (State or Foreig ountry) aryland
*	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
nd Mental Hygiene. s marked other than "natural" or Items 23a or 28a-f show umatic event, it a Medical Exactinar must be notified at	jo	Maryland B	altimore		Dunda	alk			1 ☐ Yes 2 ☑ No
r 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
23a o	aiD	8060 Kimberly	Road			2122	22	United	States
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Marital Status 1 Never Married 3 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 201 If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 ☐ No.	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	ocify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
lical	Completed	15. Decedent's (Specify only highest)		16a. De	cedent's Usual Occupive kind of work done a. DO NOT use retire	ation during most of worki	ng	16b. Kind of Business	s/Industry
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a a		12 Years 17. Father's Name (First, Middle, La	st)	P	rea Manage	18. Mother's Name	(First, Middle, I	Steel Inc Maiden Sumame)	ustry
0 0 V	o Be	Walter Adam L					•	ie Shepp	
rtraumati	ပ္	19a. Informant's Name/Relationship Mrs. Elaine C.	(Type, Print)		ailing Address (Street 160 Kimber	and Number or Rura	l Route Number	City or Town, State,	Zip Code) 21222
et s		20a. Method of Disposition		20b. Place of Dis	sposition (Name of crematory or other pla		ate	20c. Location - City o	r Town, Slale
iry or		1 Surial 2 Cremation 3 1 4 Donation 5 Other (Spe		1	anislaus C		2005	Baltimore	e, Maryland
any inju		21. Signature of Funeral Service Lie	ensee	2	22. Name and Addre Duda-Ruck 7922 Wise	Funeral F	Home of	Dundalk, 3	Inc. 1222
		23a. Part1. Enter the dyease, or co shock, or hear to lure. List	o dications that caused	the death. Do not			r respiratory arm	est,	Approximate Interval Between
ian ical ner		Immediate Cause (First disease or condition resulting in death)	_a Arterio		Cardiova				Onset and Death 30 years
ısit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence of):					
ne burial-transit	ical Examiner	that initiated events ' resulting in death) Last	c. Due to (or as	a consequence of):					
en sa esp tot nec	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	elivery Day Year
ld be detached for	by Ph	Part II. Other significant condition	s contributing to death b	out not resulting in th	e underlying cause giv	ven in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
P P	D D	morbid obesity, a	diabetes, hy	pertension	, dyslipid	emia,	1 🔀 Y	es 2□No 3□F	robably 4 Unknow
age 2 should t	Completed	Smoking, prior	nyocardiali	infarction	, , ,		24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of successions.
ctor,	Bec	25. Was case referred to medical examiner?				26. Place of Death	the second secon		
uneral dire	ို	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		e of 28c. Inju ry Wo	ner: 4 ☐ Nursing Hor ry at rk? Yes 2 ☐ No		ence 6 □Other (Sp ow injury occurred	scify)
d in by the	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In	jury - Al home, farm, tc. (Specify)	, street, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	Medical C		Physician: To the best caminer: On the basis of and manner st	of examination and/o					
Toth	ğ	29b. Signature and title of certifier Hamy askly	MP, assistant	- Professor of A	29c. Licens ledicine DOO	52859		29d. Date signed (Mor	5
7		30. Name and address of person w Harry Silber, M	no completed cause of a D., Cardiolog	death (Item 23a) (Ty	pe, Print) Johns Hopk	ns Bayview,	4940 E	aska Avenue	Baltimore, M 1 21224
Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Fegisti	rar's Signature	Sporte				

DHMH 17 Rev 1/2001

		•	For State Registrar		State of Ma	aryland	-	partment c e <i>rtificate</i> (ental Hy		005	23236	
				e (First, Middle, Las	1)						2. Date of D			3. Time of Death	
	Physicia /Medic		Georg	1111	ckinne	24					July	11,	2005	9:13 Pm	
	Examin			not institution, give		O			m, or Location		•	4c.	. County of Deat		
			Harfo: 5. Social Security N		ial Hosp		L ast birthda		re De	er 24 Hrs.	CE 8. Date of Bi	irth	HArfo		
	Funeral Director		256-12	•	M 2□F	82			ys Hours	s Min.	(Month, D	ay, Ye <i>ar)</i>		thplace (State or Foreign ountry) Orqia	
	D		Usual Residence o	of Decedent							0 44 10 1 1 2 2 2				
	arylan	_	10a. State	10b. County		10c. City	, Town or							10d. Inside City Limits 1 Yes 2 XNo	
	86-f	Director	MD	Balti	more		Ess	sex				10.00			
	with the or 2	吉	10e. Street and Nu	_{Manor} Ro	- A			10f. Zip Co					izen of What Co	ountry r	
	death with the Maryland me 23a or 28e-f show rougst be redified at	era	11. Marital Status	MailOI KO	12. Was Decedent	Ever in U.	S. 10	212 3. Was Decedent If Yes, specify		Origin? (Spe	ecify Yes or N	o- US	14. Race - Ame		
98	after or ite	Completed by Funeral	1 Never Mar	ried 2 Married	Armed Forces? 1-∃Xes 2 ☐ I If Yes, Give			If Yes, specify 1 ☐ Yes 2 ☑			Rican, etc.)		Black, White Specify: Wh		
5-0036	hours tural, o	d b	3 Widowed		Year or Dates:		162 Do	codent's Heuri O	acupation			16b K	ind of Business		
7	in 72	ojete		15. Decedent's Ed	de completed)	_ ,	(Gi life	cedent's Usual O ive kind of work of b. DO NOT use re	one during m etired)	ost of worki	ing			nion Co.	
2121	d within jiene. r then	шо	Elementary/Sec		College (1-4or s	5+)		arpento					ames o	mion co.	
3	be filed within tal Hyglene. d other than event, the Me	Bec		(First, Middle, Last)					18. Mo	ther's Name	(First, Middle	e, Maiden	Sumame)		
9113_4 Maryland	s 1 and 2 should be if Health and Mental Item 27 is marked o other treumatic eve	To	unkno	wn						nknow					
Aar	2 she and is m	1		lame/Relationship (7			19b. Ma	ailing Address (Si				-			
	1 and lealth		20a. Method of Dis	Toft /s	tep-son	20b. P	lace of Dis	47 Sug			ne HA	,	er PA ocation - City or	17331	
9 0	nt of I		1 Surial 2	Cremation 3	Removal from State	, a	emetery, c	rematory or other awn Cer	place)	į.			altimo:		
07-11-05 Baltimore,	permit. Pages Department of t importent: If its any injury or o			5 Other (Specify uneral Service Licen		1	1	22. Name and A		777					
O J	permit. Departimportimport		PR-	Tern	1 (onn	ell	11			CC	nnell Balt	yFui imo:	neralH re_MD	omeofEssex 21221	
			23a. Part1. Enter shock, or he	the disease, are mart failure. List only	lications that caused one cause on each li	d the deal	1	enter the mode o	, .	as cardiac o	or respiratory	arrest,	2016/01/2012/2014	Approximate Interval Between	
	Physician		Immediate Cause disease or conditi	ion	Kespir	ato	4	Faclu	re					Onset and Death	
~	/Medical Examiner		resulting in death)		Due to (or as	a conseq	uence of):								
		-	Sequentially list of	onditions,	b. Due to (or as	a conseq	uence of).								
5	neit .	Examiner	Sequentially list of any, leading to it Cause (Disease o	larlying or injury	((
<u> </u>	exection and ial-tra	Exa	that initiated event resulting in death)		Due to (or as	a conseq	uence of):								
39-1315	icate be executed physician and s the burial-transit	edical			d										
		Med	IF FEMALE:												
H SOD	death certifi e attending od for use as	ician/M	23b. Was decede in the past 1:		23c. If yes, outcome	2 Feta	l death	3 □Ectopic pregr					23d. Date of de Month	livery Day Year	
T.O.	000	sic	1 Tes 2	₩10	4□Pregnant a 9□Unknown	it time of d	eath	5 Other (speci	(y)						
ب م	- 6 5 F	Physi	Part II. Other sign	ificant conditions of	ontributing to death t	but not res	ulting in the	e underlying caus	e given in Pa	art I.	23e. Did	tobacco	use contribute to	o the cause of death?	
McKinner Vital Records.	uires l signe ld be	d by	8412	ures							1 [Yes 2	□No 3□P	robably 4 Sbriknown	
200	w requii	Completed									24a. Wa	ıs an		utopsy findings available	
Z e	The lav ate has page 2	E O									per	opsy formed? ~2 □ H c	death?	completion of cause of	
JC Ital	ician: Th certificate rector, pag	a)	25. Was case refe	erred to medical					26. Pl	ace of Deat	h (Check only		, 10188	2 2 140	
		To B	examiner? 1 Tyes 2		Hospital:	ent 2	ER/Outpa	tient 3 DOA	Other: 4	Nursing Ho	me 5 Re	sidence	6 ☐Other (Spe	acify)	
reorge ision of	ding Ph		27. Manner of Dea	ath 5 Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time Injur	e of 28c.	Injury at Work?		28d. Describe	e how inju	iry occurred		
Georg	ttendi death. stor: A	Certification:	2 Accident	investigatio				М	1 Yes 2			10	111		
(n >	- 0 -	THE STATE OF	4 Homicide	dataminad	28e. Place of In building, e			street, factory, o	ffice			(Street a. own, State		lural Route Number,	
	pitei Durs a nerel f		29a. Certifier	1 Cartifying 0	rywidium: To the best	tol you have	anta-tree 4	anti-version state	For Egyptic States	construines	percel place no di-	pare de	i and commer	a state)	
	To the Hospitel or within 24 hours aft To the Funerel Dic completely filled in	edical	(Check only one)	2 ☐ Medical Exa	niner: On the basis of and manner s	of examina	ition and/o	r investigation, in	my opinion,	death occur	red at the time	e, date an	d place, and due	e to the cause(s)	
	To th withir To th сощр	Me	29b. Signature an	d the of certifier					icense numb				ate signed (Mon		
			Ta	w/ 12	2			\ \tau	552	22		Jul	911,	2005	
_	5		30. Mane and add	dress of person who	completed cause of	death (Iter	n 23a) (Ty	pe, Print)	., 4		H	- N	. (2005 ce, MD	
			31. Date filed (Mo	onth Day Vend	Man Basis	rarie Sine	ature 4	0010	v M	ve,	1 (0())	CV	cora	ce, MD	
	St Regist	ate trar	JU	L 1 5 2005	7-32. Regist	J. Salyna	Aire	de.							

		1- For Amend Item 19a, 20a c, 21 per fn	त्कुर्मुमुब्बर् <u>म वृद्धिसम्ब</u> ात Me ertificate of Death		
		Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	CUU 3 Fa. Time of Death
Physici /Medio	al	Diane	Moore.	July 6	13.'02 M
Examir	er	4a. Fecility Name (If not institution, give street and number) The Johns Hookins Hospi +al	4b. City, Town, or Location of Death BALL MORE	1.74	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In vis. last birthda 214-64-0296 1 M 20 F 5 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	1953 Mary Land
yland iow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	1 /	10d. Inside City Limits
Ba-1sh	ector	Maryland N/A Bal-	timore		1 Yes 2 No
1215-0036 within 72 hours after death with the Maryland ene. ene. re Macified Examither count by motified at	Funeral Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
r death	ınera	, Armed Forces?	3. Was Decedent of Hispanic Origin? (Spei If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian, Black, White, etc.
036 urs afte aft, or if	þ	1 ☐ Never Married 2 Married 1 ☐ Yes 2 Mo If Yes, Give 7 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 152 No Specify:		Specify: Rlank
72 hor	eted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of workin		Kind of Business/Industry
d 21215-0036 filed within 72 hours aff Hygiene. Hygiene than "natural", or ant, Itse Modiful Exami	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Urse	1	tealth Care
be filed ital Hygir of other	Be	17 Eather's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	en Surname)
Maryland of 2 should be file lith and Mental Hy 27 is marked oth	ဥ	19a, Informant's N. 19/Relationship (Type, Print) (Husband) 9b. Ma	illing Address (Street and Number or Para	Route Number, Cit	opeland y or Town, State, Zip Code)
and 2 and 2 m 27 is		Mr. Jar Mr. Javis Floyd 26	51 Huron St.	Balto	Md. 21230
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If fine 27 is marked other than "natural", or items 29a or 28a-1 show any injury or other traumatic event, It.e Marical Examinational to notified at once.		1 Burial 2 Cremation 3 Removal from State	rematory or other place)	2005 Z	Location - City or Town, State
Baltin permit. Pa Departme Importent any injury once.		21. Signature of Funeral Service Licensee Joseph L. Russ	22. Name and Address of Facility	2005	Dalto, Ma.
0 2252		Hnatomy Board per dvr	loseph L. Kuss tu	Balto. M	d. 2/2/6
Dharistan		23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):			unknown
Examiner	Į.	Sequentially list conditions, if any, leading to immediate b. Trective E Due to (or as a consequence of):	ndocarditis		bweeks
cuted and ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
same of the second of the physician and surial-transit is the burial-transit.		resulting in death) Last Due to (or as a consequence of):			
	ledicai	d			
Box 6 death certific	Physician/M		3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
. 5 .5	Jysic	1 ☐ Yes 2 Tho 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Month Bay 15an
ecords, P.O. law requires that the as been signed by thi 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the			o use contribute to the cause of death?
Records, he law requires t e has been signe age 2 should be o	Completed	End Stage Renal D	isease		2 No 3 Probably 4 Unknown
The second secon	omp			24a. Was an autopsy performed	
of Vital F Physician: Th r this certificate ral director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	NO 12,103 212,00
Of Phys	n: To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Mpatient 2 ☐ ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 2	ne 5 Residence 8d. Describe how in	6 ☐ Other (Specify)
Vision Attending r death. sctor: After	catio	1 Solution 5 Pending (Month, Day Year) Injur 2 Accident investigation 3 Suicide 6 Could not be 10 Place of Accident 10 Plac	y Work? M 1 ☐ Yes 2 ☐ No		
Division of Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	8f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
To the Hospitel or A within 24 hours after To the Funeral Direct completely filled in b.	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, a investigation, in my opinion, death occurre	nd due to the cause od at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
To the within To the complete	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		Channing Valles 1	ND RES- OOC) J	Jy 6, 2005
1		30. Name and address of person who completed cause of death (Item 23a) (Type Channing Paller) 600 N	ND RES-000 Wolfe St., Br	Altimore	E.MD 2/287
St Regist	ate rar	1 31. Date filed imonto, Dav. ream ** La., L 32 Hedistrar's Signature			
DHMH 17 Rev 1/2	7 : 3	TOT 15 2005 Beaus &	fret		

ORIGINAL

			State	/ Department of Health and Me Certificate of Death	ental Hygier	пе	
			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. I 2. Date of Death	2005	3. Tine of Dealth Q
4	Physici /Medio		Margaret M. Mann	ing	July -	Day Year 7, 2005	5:17 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Sinai Hospital of Baltin 5. Social Security Number 6. Sex 7. Age (In yrs. las	thirthday If Under 1 Year If Under 24 Hrs	8. Date of Birth	N/A	place (State of Femilia
	Funeral Director		241-52-1517 1 M 2XF 77	Yrs. Months Days Hours Min.	Month, Day, Yes	1928 North	place (State or Foreign
	D	٥	Usual Residence of Decedent		THUILLI IS		Carpina
	ehow	'n	10a. State 10b. County 10c. City, 1	Town or Location		1	10d. Inside City Limits 1 Yes 2 □ No
	28a-f	Funeral Director	Maryland IV / T 50	altimore 101. Zip Code	10g.	Citizen of What Cour	
	3a or		2900 The Alameda	21218		1156	4
	ems 2	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	or it	by Fu	1 ☐ Yes 2 1 No If Yes, Give 3 X Widowed 4 ☐ Divorced 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	·	Specify: D	nak
5-0036	72 hours after death with the Maryland natural; or items 23a or 28a-f ehow ileat Examinat must be notified at	ted t	15. Decedent's Education	16a. Decedent's Usual Occupation	16b.	. Kind of Business/In	dustry
215	within 7. ene. than "n	Completed	(Specify only highest grade completed) Elementam/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of workin life. DO NOT use retired)	· ·	*	1.4
2	filed with Hygiene. sther than	Con	17. Father's Name (First, Middle, Last)	Homemaker 18. Mother's Name	/Cimt Middle Maid	Dome	STIC
Maryland	d be fi	To Be	Kelly Swith	Rosa		En sumame)	
aryl	and Mental s marked of aumatic eve	ř	19a. Informan Name/Relationship (Type, Print) 50 n	19b. Mailing Address (Street and Number or Rural	Lee Route Number, Cit	ty or To State, Zip	Code)
_	and 2 salth a n 27 ls		Mr. Salvatore Manning		reda	Baltu.	Md.21218
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show amy injury or other traumatic event, Ital Marylou Examinating must be notified at any injury or other traumatic event, Ital Marylou Examinating must be notified at ange.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	netery, crematory or other place)	***************************************	Location - City or To	own, State
Iţi m	permit. Pag Department Important: any injury c		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	inicy valley.	2005 1	moniu	m, Ma.
Ba	permit. Departr Importa any inje		Caroph L. Buss	22. Name and Address of Facility JOSEPH L. KUSS 2222-WINDOWS AUR	Funera	y Home Md. 212	, P. A.
			23a. Part I. Inter the divises, or complications that call the death, shock or hear fairlie. List only one cause on each line.		respiratory arrest,	Marara	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	nia			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequent				
	100	e	Sequentially list conditions, Due to or as a consequenceuse. Enter Underlying Cause (Disease or injury	nce of/k			
1	cuted nd ransit	Examiner	that initiated events c.				
90,	rate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequent	ice of):			
8760,	physic the b	dicai	d				
Box 6	deeth certific e attending p id for use as	√Me	IF FEMALE: 23c. If yes, outcome of pregnant	у		23d. Date of delive	erv
	that the deeth certific ed by the attending p detached for use as i	Completed by Physician/Med	in the past 12 months? 1 Yes 2 100 4 Pregnant at time of deat			Month	Day Year
P.0	d by the	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting	ag is the underking source in Real	G2a Did tabasa	co use contribute to the	no seven of death?
ds,	w requires that the been signed by th should be detache	d by	Diabetes mellitus	ig in the underlying cause given in Part I.	1 Yes		
cor	> 0 0	iete	Hypothyroidism		24a. Was an	24b. Were auto	ppsy findings available
of Vital Records,	o - 0	ошо	Consestive heart failure		autopsy performed 1 Yes 2 4	? prior to condeath?	mpletion of cause of
/ital	ysiclan: Th is certificete director, pag	Bec	25. Was ca referred to medical	26. Place of Death	(Check only one)		
of V	S O TO	2	1 ☐ Yes 2 ☐ HOSpital: 1 ☐ Inpatient 2 ☐ EF	Other: 4 Nursing Hom 8b. Time of 28c. Injury at 28			y)
	the man	tlon	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	8b. Time of	8d. Describe how in	july occurred	
Division	Attendia er death. ector: A by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, street, factory, office	8f. Location (Street City or Town, Str	and Number or Rura	al Route Number,
ā	Ital or irs afte ral Dir led in			1			<u> </u>
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 General Technology (Check one) 1 General Technology (Check on	edge, death occurred at the time, date and place, an a and/or investigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as si and place, and due to	tated. o the cause(s)
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Mec	29b. Signature and title of certifier	29c. License number		Date signed (Month,	Day, Year)
	-		* Hochel Hartman M.D.	RES-000) Ju	dy 7,2	005
	4		30. Name and address of person who completed cause of death (Item 2	RES-000 Sihai Hospital of	4 14.	-1 /	
	Sta	te	Rachel Hartman, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signatur		Ballin	200	
	Regist		JUL 1 5 2005 Bearing 18	parte			

Manning, Margret

		•	1 - For State Registrar	State of Marylar	-	artmen rtificate						05	23239
	Physici /Medic		1. Decedent's Name (First, Middle, Last) RuTH	NEISSE	n					2. Date of Dea Month 300	Day	Year W 5	3. Time of Death
	Examin	-	4a. Facility Name (If not institution, give	street and number)				Location of			4c. Cou	nty of Death	
	李		GOOD SAMARITAN H 5. Social Security Number 6. Sec		last hirthday	Ba If Under		ore (8. Date of Birti	<u> </u>	N/A	place (State or Foreign
П	Funeral Director			M 2 X F 95	Yrs.	Months	Days	Hours	Min.	July 3	1910	Cou	ontry) Yland
	ъ		Usual Residence of Decedent								,		
	Marylan I-f show	tor	10a. State 10b. County Maryland Harford		ity, Town or Lo Darli	ngton	l I						10d. Inside City Limits 1 ☐ Yes 2 X No
	or 28g)irec	10e. Street and Number			10f. Zip	Code				10g. Citizen o		ntry?
	23a	rai [2000 Glen Cove	Road			210					USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f show important: If item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other treumatic svent, ite Medical Enarting must be realthed at ances.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar Specify:		ecfy Yes or No- Rican, etc.)	Spe	tace - Ameri stack, White, cify: Wh:	
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usua kind of wo	rk done d	turina mos	t of worki	ing	16b. Kind of	Business/In	ndustry
21	han "	mple	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	life.	DO NOT us	se retired)			٨٥٥		
22	e filed within al Hygiene. I other than 'vent, the Me		12th 17. Father's Name (First, Middle, Last)		BOOK	keepe	er	18. Mothe	er's Name	(First, Middle,		ountin	<u>ıg</u>
Maryland	ould be f Mental I warked of	To Be	James Garfield P	arlett						Kettle			
ary.	should and Menials marker eumatics	ř	19a. Informant's Name/Relationship (Ty		19b. Maili	ing Address	(Street a			Al Route Numbe			o Code)
	1 and 2 Health a tem 27 ls		Douglas D. Prunty	(P.O.A.)	2000	Glen	Cov	e Roa	ad, I	arlingt	on, Ma	arylan	d 21034
altimore,	permit. Pages 1 an Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F		Place of Dispo cemetery, cre	osition (Nan matory or o	ne of ther plac	e)		Date	20c. Locatio	n - City or T	own, State
Ë	Pag ment tant: I		'4 ☐Donation 5 ☐Other (Specify)	Du	1aney	Valle	у М.	Grdn	ns 7/	18/2005	Timor	ium,	Maryland
Ball	Departimon Important in portant i		21. Signatura of Furna al Se vi e Lig sos	awson	M	2. Name an litche	11-W	liedet	feld	Funeral	L Home	, Inc.	
	40344		Martin D. Law 23a. Part1. Enter the disease, or compl	Son	6	500 Y	ork_	Road.	. Ba	timore.	Marv	Land 2	1212 Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each tine.	50 110. 01.		,	9, 00011 00			, 550,		Interval Between Onset and Death
į	/Medical Examiner		resulting in death)	Due to (or as a conse	-	41	NFIE	4510	IN)				DMS
/	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse		, ,							
0,	be executed sicien and burial-transit	i Exan	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):								
8760,	icate b physic s the bi	edicai	•	d									
O. Box 6	death certif e attending ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	23c. If yes, outcome of pregr 1 Dive birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3[⊒Ectopic pr ⊒ Other (sp						Date of deliv Month	ery Day Year
۵.	that the de ed by the detached		Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	underlying c	ause give	en in Part I	l.	23e. Did to	obacco use c	ontribute to t	the cause of death?
ds,	uires tha signed Id be de	d by	EUMISTIVE INDA	IT FAILURG	,					1 🗆 Y	res 2 No	3 Pro	bably 4 Unknown
Vital Records,	law requires as been sign 2 should be	Completed								24a. Was	an 24	b. Were auto	opsy findings available
Re	o = 0	mo								autop perfo	rmed? 2 X No	prior to co death? 1 Yes	ompletion of cause of
ital	iclan: Th certificate rector, pag	O	25. Was case referred to medical					26. Place	e of Deatl	n (Check only o			22.113
	di ib	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DC	Oth	er: 4 □ Nt	ursing Ho	me 5 🗆 Resid	dence 6 🗆	Other (Speci	fy)
o uo	ding After fune	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of tnjury (Month, Day Year)	28b. Time of Injury	of 2	28c. Injun Worl 1 □ 1	yat k? Yes 2□		28d. Describe h	now intury occ	curred	
Division of	or At	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory	y, office	_		28f. Location (5 City or Tox		mber or Run	al Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my kr iner: On the basis of examin and manner stated.	nowledge, dea nation and/or in	th occurred nvestigation	at the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the red at the time,	cause(s) and date and plac	manner as s ce, and due t	stated. to the cause(s)
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	10		30. Name and address of person who con Semble 1-30		em 23a) (Type	Print)	2002	N BL	, כני	SATIM			
ľ	St. Regist	ate rar	31. Date filed (Month, Day, Year)	82. Registrar's Sign									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

1 - For Stata Registrar Certificate of Death Rag. No. () 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Month Year Nancy - Wilson No...ic 05:18 am Nancy Nioma Nilson July 13 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore of Maryland Medical Center N/A University If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 3. Month Day Ye January 22, 5. Social Security Number 7. Age (In yrs. last birthday) 62 Yrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** 1□M 2 1 F ^{Year} 1943 189-34-2360 Pennsy'ivania **Director** Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Pennsylvania Centre Directo Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2426 Little Marsh Creek Road 16841 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: þ 3 X Widowed 4 □ Divorced "netural" Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fi f Health and Mental H item 27 is marked of Cyrus Shaffer Mrtle Watkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2426 Little Marsh Creek Road Howard PA 16841 Melvin E. Nilson, Jr. / Son permit. Pages 1 and Department of Healti Important: If item 27 any injury or other t other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Pages nent of t cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 7/18/05 Walker Twp. Pennsylvania * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Christina L. Hilton 2. Name and oddr. s of Facility Leonard . . . U.K., Inc 5505 Harrord Road . . . mestina Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pulmonary Hu
Due to (or as a consequence of) 2momns disease or condition resulting in death) Hypertensiun /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Day Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? cate has autopsy performed? certificate 2 🗆 No 2 1 Yes Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) After thi funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending 1 Natural within 24 hours atter uses...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 a layen, MD P17646 July 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Grene St. Baltimore, MD 21201 Jennife a. Taylor, University of Maryland Medical Center, 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 1 5 2005 Registrar Blown It Sporte

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Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			232 Part 1. Enter the disease, or or	mplications that caused the	death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Interval Between
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(Chack only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	Delli	ŏ	20a Contition 156 Certifying	Physician: To the best of m	y knowledge de	ath occurred at the	time, date and place	a, and due to the ca	ause(s) and manner	as stated. 2
29c. License number 29d. Date signed (Month, Day, Year) DO177 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM MUSSILL NO 3200 Weller Blue 30177 MOZ	tely	ica Gi	(Check only 2 Medical E	xaminer: On the basis of ex-	amination and/or	investigation, in my	opinion, death occi	urred at the time, d	ate and place, and c	due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM A PUSSILL NO 3200 WELLE BLUE BULE BULE BULE 32. Reflected's Signature.	прів	Ne Ne	29h Signature and title of certifier	4.13.114.117.01.010.00		29c. Licer	nse number	2	9d. Date signed (Mo	onth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William MRUSSIII ND 3800 Wel New Blue Buttone MDZ	3		1 00	w hard		•	30,00	_ /	Sul. 12	2005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM MRUFSELL NO 3800 WELLE BLUE BUL TOUR MIZ			will	myunth			10186	,	12,	6000
21 Day Flad Month Day York 22 Bookstrats Signatures			30. Name and address of person v	vho completed cause of death	h (Item 23a) (Typ	e, Print) B 200 C	Nort New Y	sive 3	outition	4 MD 21.
State 31. Date filed (Month, Day, Year) 32. Hepstrar's Signature	Ç.	tate	31. Date filed (Month, Day, Year)	32. Redistrar's	Signature	hoests)				

		-	- FOr	epartment of Health and M Certificate of Death		ne 2005 23242
	Physicia	an	1. Decedent's Name (First, Middle, Last) Virginia Anna Powell		2. Date of Death Month July	Day Year 3. Time of Death 13, 2005 8:15 A
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number) Westminister Nursing Home	4b. City, Town, or Location of Death Westminister		4c. County of Death Carroll
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd 1 ☐ M 2 ☐ F 86 Yrs	(ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
Maryland	f show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Maryland Carroll	r Location Finks bwrg		10d. Inside City Limits 1
with the J	a or 28a- be roll	Direct	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
5-0036 72 hours after death with the Marvland	ital Hygiene. od othar than "naturel", or itams 23a or 28a-f show event, it si Medical Exscrimer must be notilised at	by Funeral Director	985 Ridge Road 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	21048 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2⊠ No Specify:	ecify Yes or No- Rican, etc.)	U. S. A. 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	ie. nan "naturel" Medical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) (GElementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	ring	b. Kind of Business/Industry
land 21	ental Hygien ked othar th ic event, Its	To Be Cor	12th Grade 17. Father's Name (First, Middle, Last) Louis Franke		e (First, Middle, Mai ia Schult	
Maryland	t of Health and Ments If Item 27 is marked or other treumatic e	-	19a. Informant's Name/Relationship (Type, Print) 19b. M	Mailing Address (Street and Number or Rur 5 Ridge Road, Finks		
altimore,	nent of Hea		20a. Method of Disposition 20b. Place of Disposition 1 W Burial 2 Cremation 3 Removal from State	isposition (Name of crematory or other place) Oly Redeemer 7/15,	Date 2007/2005 Bd	c. Location - City or Town, State altimore, Maryland
Balt	Department of Important: If I any injury or one		21. Signature of Euneral Service Licensee	22. Name and Address of Facility Sc 3331 Brehms Lane,	Baltimore	, Maryland 21213
	Medical was the private and th	icai Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, isating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)	the Variable		Approximate Interval Between Onset and Death 24 Land 25 yr. 25 yr. 25 Jr.
O. Box 68	the attending phoches to the description of the des	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Records, P.O	n signed by the audid be detached it	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
	(Q CT	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
	leath. leath. tor: After the fune	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpi 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 4 Homicide Getermined 28e. Place of Injury At home, farm building, etc. (Specify)	atient 3 DOA Other: 4 Nursing Home of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	et and Number or Rural Route Number,
	hours nerel	edical Ce	29a. Certifier (Check only one) 12 Certifying Physicien: To the best of my knowledge, of the control of the co			
,	within 24 I	Me	29b. Signature and title of certifier	29c. License number	29d	Date signed (Month, Day, Year)
_	X		30. Name and address of person who completed cause of death (Item 23a) To burn. Middleton (e 88 7)	ole Read his	Amin's	ky mo 21157
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUL 1 5 2005 Registrar's Signature	per		

			State of Maryland / Department of Health and Mer	ntal Hygien	ne
		_	1- State Registraramend item #1 per phy 2845 7/18/05 ate of Death	Reg. N	2005
	Physicia		Decedent's Name (First, Middle, Last) 2.	Date of Death	Day Year () 10
	/Medic	al	James Piece- JAMES PIERCE	July i	, 2005 8.25pm
	Examin	er	4a. Facility Name (If not institution, give street and number) Missuland General Hospital Baltimore City		4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. 8.	Date of Birth Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director	-	215-10-3/59 A 85 No.	ov 19, 1	919 country) unk
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary Be-f sh	to	MD Baltimore		1★ Yes 2 No
	ith the	Director	10e. Street and Number 10f. Zip Code	10g. 0	Citizen of What Country?
	e 23e	eral	501 W. Franklin Street 21201		USA
' O	within 72 hours after death with the Maryland sne. than "natural", or itema 23a or 28a-f show he Madical Examinar must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☑ Never Married 2 ☐ Married 1 ☑ Never Married 2 ☐ Married	an, etc.)	14. Race - American Indian, Black, White, etc.
000	ours a	ğ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: white
21215-0036	"natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	unk 16b.	Kind of Business/Industry unk
12	iene. than	ошо	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired) unk		
פ	be filed within ital Hygiene. od other than ' event, the We	BeC	17. Father's Name (First, Middle, Last) unk 18. Mother's Name (Fi	irst, Middle, Maide	en Sumame) unk
ylaı	should b and Ments s marked	To			
Maryland	C1 10 = 00		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rural Relationship</i>) 19c. T. J. J. J. J. J. J. J. J. J. J. J. J. J.		
	1 and Health tem 27 other tr		Maryland General Hospital 827 Linden AVenue Balti 20a. Method of Disposition Date 20b. Place of Disposition (Name of Date		D 21201 Location - City or Town, State
<u>o</u> E	Pages ent of nt: If I		1 □ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 ☑ Other (Specify) in ≰tate		
Baltimore,	permit. Pages 1 and Depertment of Heali important: if Item 2 any injury or other once.	Ì	21. Singler Fund Style Licensee R. na. d. S. Wade Director 22. Name and Address of Facility State Anatomy Board	655 W B	altimore Street
<u> </u>	82588		Baltimore, MD 21201		artimore bereet
I.			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re shooth or heart failure. List only one cause on each line.	spiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		
	Examiner		Due to (or as a consequence of):		
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):		
	be executed icien and burial-transit	Examiner	that inflated events c. resulting in death) Last Due to (or as a consequence of):		
8760,	sate be executed obysicien and the burial-transit	ical E	Due to (or as a consequence or).		
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Вох	leath certific ettending p I for use as I	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
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Δ.	law requires that the de as been signed by the e 2 should be detached f			23e. Did tobacco	o use contribute to the cause of death?
rds	w requires been sign should be	ed by		1 🗆 Yes	2 No 3 Probably 4 Donknown
Records,	e taw re has bee	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	Th page	Сош		performed? 1 Yes 2 1 1 1	death?
Vital	sician: Th certificate irector, pag	Be	examiner?		
of	ding Phys h. After this funeral di	n: To	1 Inpatient 2 LEHOutpatient 3 DOA 4 Nursing Home	 Residence Describe how in 	6 ☐Other (Specify) jury occurred
ion	Attending Physician: r death. ector: After this certific. by the funeral director.	atlo	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		
Division	or Atte	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	pital o			due to the sauce	/a\ and manuscap stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edicai	(Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	at the time, date a	and place, and due to the cause(s)
	To the To the Comp	Ň	20h Cignoture and title of codifier	29d. [Date signed (Month, Day, Year)
•			\$ 1000mm 2000 200 200 200 200 200 200 200 2	J	uly 1, 2003
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahman Soatian m.D. (General 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature	1 Hace	0: 401
	Sta	ite	31. Date filed (Month, Day, Year) 32. Pagistrar's Signature	1 1100	P1 101
	Registr	ar	JUL 1 5 2005 Region & Frank		

				Department of Health and Mental Hy	giene
			1 - State Registrar 1. Decedents Name (First, Middle, L@st)	Certificate of Death	Reg. NO 005 23244
	Physici /Medic		MARY PERRIN	Month 6	Day Year 8 10 4 M
	Examin		4a. Facility Name (If not institution, give street and number) Houseword U. Awgels Assisted	4b. City, Townsor Location of Death,	4c. County of Death
	Funeral		5. Social Security Number 0 6. Sex 7. Age (In yrs. last bit	Months Days Hours Min. (Month, Da	th y, Year) 9. Birthplace (State or Foreign Country)
-	Director		Usual Residence of Decedent	reb 15,	1921 New York
	Maryla -1 shov II: 4 :	tor	10a. State 10b. County 10c. City, Tow	Severna Park	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th the	Director	10e. Street and Number		10g. Citizen of What Country?
	ath wi	ralD	118 Arundel Beach Road	21146	USA
920	72 hours after deeth with the Maryland natural; or Items 23a or 28a-f show Stal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	14. Race - American Indian, Black, White, etc. Specify: white
21215-0036	d within 72 hours jiene. r than "natural", r than "natural",	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
121	within iene. than "	omp	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired) Secretary	community college
	othe othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	
ylaı		ToE	Herbert Osborne	Mildred Bene	edict
Maryland	2 a a a a a a a a a a a a a a a a a a a		l l	p. Mailing Address (Street and Number or Rural Route Number	
	es 1 and of Health filem 27 r other tr		20a. Method of Disposition 20b. Place o	07 Evergreen Road Severna P of Disposition (Name of part) by, crematory or other place)	20c. Location - City or Town, State
Baltimore,			*4 \ Donation 5 □ Other (Specify)		
Bal	permit. Pag Department Important: any injury o		21. Signatur Funeral Strvice Licensee	22. Name and Address of Facility State Anatomy Board 655 W. Baltimore, MD 21201	
i i	Pnysician /Medical	C IV	23a. Part 1. Enter the disease, or complications that caused the death. Do shock for heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a	not enter the mode of dying, such as cardiac or respiratory and	rest, Approximate Interval Between Onset and Death
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	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):	011 002 7 0118
Ć.	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last C	of):	
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dical	d		
Box 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_	23d. Date of delivery
P.O. B	res that the death signed by the atte t be detached for	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify) □	Month Day Year
	taw requires that the as been signed by the 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in	in the underlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death? (es 2 No 3 Probably 4 Unknown
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of V	d is	To B	examiner? 1 Yes 25 No Hospital: 1 Inpatient 2 ER/Ou	Other	
	ding After fune	tlon:	1 Natural 5 Pending (Month, Day Year) I	Time of	ow injury occurred
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		Street and Number or Rural Route Number, m, State)
D	spitat o ours aft ieral Di filled ir			e, death occurred at the time, date and place, and due to the d	
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	(Check only 2 Medical Examiner: On the basis of examination are one)	nd/or investigation, in my opinion, death occurred at the time, o	date and place, and due to the cause(s)
	with Con	Σ	29b. Signature and title of certifier . Colours W	29c. License number 1 -0018566	29d Date signed (Month, Day, Year)
10-			30. Name and address of person who complete cause of death (Item 23a)	(Type, Print) Admikel Cochicene Dr.	ANUADOLIS MINO
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	hode	

JET 05-04755 Nancy D. Rasnake

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Nancy D. Rasnake /Medical 3 2005 4c. County of Death July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Anne Arundel 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Year) Yrs. Director 72. 217**-**26**-1**798 1932 Aug. NJUsual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "netural", or items 23a or 28a-f show other treumatic event, the Medical Examinar most be notified at 10d Inside City Limits Funeral Director Maryland Anne Arundel 1 Yes 2 XNo Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 696 D Street 21122 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo þ 3 XWidowed 4 ☐ Divorced White "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: if item 27 is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Christ Rosie Rasnake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tree 2002. Catherine Robey - daughter Street, Pasadena, 696 D MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory July 15 Baltimore, MD 21. Signature of Funeral Service Mensee 22. Name and Address of Facility 3111 Mountain Rd. Pasadena, Maryland 21122-Stallings FH 23a. Part I. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive atheroseleunti cardialescular dispesso /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð certificate has been s rector, page 2 should Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24a Wasan 24b. Were autopsy findings available prior to completion of cause of d ?? 1 Y Yes 1 Yes 2 🗆 No 2□ No 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No ို this 2 X ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident Certification: After t 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred s after dec. 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME July 15 2005 completed cause of death (Item 23a) (Type, Print) 111 Penn Street 30. Name and address of person who E. Sauthall, MD Baltimore, Maryland 21201 amela 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar Close de farle

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				State of Maryland / Department of Health and N	lental Hyg	iene	
)				Registrar Certificate of Death		eg. No. 2 A A E	
Z		Physici	an	1. Decedent's Name (First, Middle, Last)	Date of Deat Month	Day Year	3. Time of Death 6
		/Media	cal .	FRANCES R. MOCHE	JULY	12 2005	12 44P M
*		Examir	ier	4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
L				5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth		ORG place (State or Foreign
~		Funeral Director		219-18-7883 10 M 20 F Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Con	netry)
4				Usual Residence of Decedent		Z-1. 18.11)	713000
0		arylan show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 No
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7		with th	Dire	10e. Street and Number 10f. Zip Code	1	Og. Citizen of What Co	intry?
12		s 23a	erai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ooifu Von or No-	14. Race - Amer	ican Indian
5,5		tter deal	F	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto 1 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes, Give Year or Dates:	Rican, etc.)	Black, White	, etc.
FRPIRET	936	or or	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: (1)	hite.
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7	Maryland	8 g g g	Be c	James G. Kinnick Essie	11000	ho:	
12	Z	2 should is and Meni is marked	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run.	al Route Number	r, City or Town, State, Z	ip Code) 2122
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5	ē,	of H		cometent cromatons or other place	ate	20c. Location - City or	Town, State
we,	Baltimore,				5.05	Timonium	mo
S	alt	permit. Pag Department Importent: eny injury o		21. Signature of Funeral Service Licenspee / 22. Name and Address of Facility	BALTIN	KORE, MD ?	21234.
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				23a. Part1. Enter the disease, of complications that coused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one course on each line.	or respiratory arr	est,	Approximate Interval Between Onset and Death
		Physician		Immediate Cause (Final disease or condition resulting in death)		Ų.	Oriset and Death
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	Вох	death certific attending p	lan/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delift Month	very Day Year
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	٩.	that the ed by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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	ta	en: 7 tificat tor, p	Be C	25. Was case referred to medical 26. Place of Deat			2L 1N0
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	n o	ding Phys n. After this funeral di		27. Manner of Death 1 (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Injury 28c. Injury 2		ow injury occurred	
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	Division of Vital Records, P.O.	or At after of Direct in by	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	treet and Number or Ru n, State)	rai Houte Number,
		spitel ours a nerel filled		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the c	ause(s) and manner as	stated.
		To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, d	late and place, and due	to the cause(s)
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		1		an morris MO D58646		July 1	3 200+
_	17) '		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0	1	
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		St Regist	ate trar	JUL 1.5 2005			

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			1 - State Registrar ame	end ite	em #3 pe:	c ph	y g845	C _P	artment of F	Death			Reg. N		15	2321.0
	Physici /Medic		1. Decedent's Name (Last)							2. Date of D Month JULY 3	D	ay Y	ear	20;47pml
	Examir		4a. Facility Name (If n 813 8TH ST		give street and n	umber)			4b. City, Town, o	r Location o	of Death		4	PRINCE		RGE
Ī	Funeral Director		5 Social Security Nur 386-30-6609		6. Sex 1 🕅 M 2 🗆 F	7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of B (Month, E AUG. 10	lirth Day, Yea	(r) 30 N	Birthp Cour 11 CH I	elace (State or Foreign stry) CAN
	yland how		Usual Residence of D 10a. State	Decedent 10b. County			10c. City, To	own or Lo	ocation						1	0d. Inside City Limits
	8e-fs	Director	MD		GEORGE		LAURI	EL					-			1 X X Yes 2 □ No
	with th		10e. Street and Numb						10f. Zip Code				10g. C	Citizen of Wh	at Cour	ntry?
	ns 23	Funerai	813 8TH S	IKEEI	12. Was De	cedent E	ver in U.S.	13.	20707 Was Decedent of E	lispanic Orio	nin? (Spe	city Yas or N	10.	USA 14. Race -	Americ	ean Indian
2-003p	hin 72 hours after death with the Maryland e. en "naturel", or tems 23e or 28e-f show Meulical Exard nermust be rixifilied ut	by	1 ☐ Never Married 3 🛣 Widowed 4	_	Armed F	orces? 2[X]N ive			Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican	, Puerto	Rican, etc.)	•0		White,	etc.
2-C	72 ho natur	Completed		5. Decedent's	s Education	')	16	Sa. Dece	dent's Usual Occup	ation	of worki	na	16b.	Kind of Busin	ness/Ind	dustry
N	il a s	mpie	Elementary/Second		College		+)		kind of work done DO NOT use retire			9		0011077114		
Z		e Co	11 17. Father's Name (Fi	irst. Middle. L	ø ø			CEM	ENT FINISHE		r's Name	(First, Middl		CONSTRUC	21101	· · · · · · · · · · · · · · · · · · ·
and	0 m 2 >	To Be	FRANK J. RE		,							LAUGHL IN		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
ary	should be ind Menta s marked umatic ev	-	19a. Informant's Nam		ip (Type, Print)		1	9b. Maili	ng Address (Street	·				or Town, St	ate, Zip	Code)
, Mai	os 1 and 2 should b of Health and Ments i item 27 is marked r other treumatic e		JAMES REINE	LT / BRO	OTHER			710	MAIN STREE	T, LA	JREL,	MARYLA	AND :	20707		
altimore,	Pages 1 nent of He ent: If iten ury or oth		20a. Method of Dispo 1XX Burial 2 ☐ 1 4 ☐ Donation 5	Cremation	3 □Removal from	n State	ceme	tery, crei	osition (Name of matory or other pla EMETERY		7/7/20	oate 005		Location - Ci AUREL, N	•	
Ball	permit. Pages Department of Importent: If if eny injury or once.		21. Signature of Fund	eral Service L	icensee	0	هـ		2. Name and Addre		1 1	ECK FUNE LAUREL	ERAL I	HOME, IN	NC. 20707	7
	Pnysician /Medical Examiner		23a. Part1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)		a MYO	CARDI	the death. De. AL INFA	RCTIO		ng, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between Onset and Death I NUTES
	LAGITIME	<u>_</u>	Sequentially list cond	ditions,	b		ARTERY		SE SINCE						1	1978
λ.	ted nsit	nine	cause. Enter Underly Cause (Disease or in	ying jjury	Dide to	(as a	C.C. I SAGE CO. COM. III.	ac cej								
۲,09/89	ficate be executed physician and is the burial-transit	edicai Examiner	that initiated events resulting in death) La	st	c. Due to	o (or as a	a consequenc	e of):								
_			IF FEMALE:									-	1		T.	
C. Box	The law requires that the death certif te has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent print the past 12 mm 1 Yes 2 1 9 Unknown	onths?		birth : nant at	of pregnancy 2 Fetal dea time of death		□Ectopic pregnanc □ Other (specify) _	Ą				23d. Date of Month		Day Year
ecords, P.	uires that signed b ld be deta	by	Part II. Other signific		ns contributing to	death bu	it not resulting	g in the u	inderlying cause giv	ven in Part I.						ne cause of death?
o o	w requir s been si should	Completed										24a. Wa	ıs an	24b. We	re auto	psy findings available
He	The lav	шо										per	opsy formed?	prid	or to con th?	impletion of cause of
Vital H	(0	Be C	25. Was case referre	d to medical						26. Place	of Death	1 Yes		10 1 -	1 185	2 140
o 	Physic this ce al direc	10 1	examiner? 1 ☐ Yes 2X N	ło		-	nt 2□ER/	Outpatie	nt 3 DQA Ott	ner: 4 □ Nu	rsing Hor	me 5 k Re	sidence	6 Other	(Specify	y)
Division	ling f	Certification;	27. Manner of Death 1 X Natural 2 Accident	5 Pending investig	ation	of Injur nth, Day	Y Year) 28t	o. Time o Injury	Wo	yat rk? Yes 2 □ t		28d. Describe	e how in	jury occurred		
	tel or Attend rs after death el Director:	Certifi	3 Suicide 4 Homicide	6 Could n determi	ned 289. Plac	e of Inju ding, etc	iry · At home, :. (Specify)	farm, st	reet, factory, office			28f. Location City or T			or Rura	I Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	ledical	29a. Certifier 1 (Check only 2 one)	Certifying Medical E	xaminer: On the	basis of nner sta	examination	dge, deat and/or in	h occurred at the tri evestigation, in my c	me, date and opinion, deat	d place, a th occurr	and due to th ed at the time	e cause e, date a	(s) and mann nd place, and	er as st d due to	tated. o the cause(s)
)	To the within 2 To the comple	Σ	29b. Signature and ti	nott	Mu	Pa	~/	D	- W-		53	2	_	ills		Day, Year) 2005
			30. Name and address						Print) STREET, LA	JREL. M	ARYI A	ND 2070	7			
		ate	31. Date filed (Month	, Day, Year)	32.	Renistra	r's Signature		_		I tall	20101				
51	Regist	rair		JUL 1	2002	Si Ma	w B	P	STATE OF THE PARTY						0.00	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2005 July 13, **Physician** J. Rindone, Sr. 7:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**€**M 2□F Italy 96 Director 212-32-2578 Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XX\\No Timonium Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21093 2525 Pot Spring Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet d 2 should be filed within 7 in and Mental Hygiene. filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employeed Barber n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Cimino Gaetano Rindone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is any injury or other trangates. 3623 Woodholme Drive Jarrettsville, Maryland 21084 (Daughter) Mrs. Maria Heer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 Acther (Specify) Entembrent Dulaney Valley Mausoleum 7/16/2005 Timonium Maryland ` 4 □Donation 21. Signature of Fin All Se 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part1-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician A Squation Procumonia Due to bras a consequence of): disease or condition resulting in death) /Medical Examiner partial bowel obstruction possible Sequentially list conditions, Chaite for as a consequence of cause. Enter Underlying Cause (Disease or injury Examine requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the b IF FEMALE: for use a 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown embolism, Deep vein thrombosis, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hbullation with vapid ventricular vegoonse autopsy performed? Yes 22 No 2 No testicular caucer 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 12 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P
 24 hours after death.
 Funeral Director: After to Certification: 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident investigation 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00000547 July 14, 200 S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mayjoy Mejig North charles street Tourson, Manyland 31. Date filed (Month, Day, Year) State JUL 1 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle 1 ast) **Physician** /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Peath Examiner Maryland Medica IMOVE 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 2 🗆 F Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10c. City, Town or Local 10b. County or 28a-f show other traumatic evant, the Medicul Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? **USA** permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " name y injury or other traumatic average. Funeral . Was Decedent Ever in U.S. Armed Forces? 1 _____ Yes___ 2 ___ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubas, Mexican, Puerto Rican, etc.) Race -American Indian Black 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOTuse retired) 15. Decedent's Education (Specify only highest grade completed) the Grade College (1-4or 5+) 18. Mother's Name (First, Middle, (First, Middle, Last) Maiden Sumame Be brother 20b. Place of Disposition Date 20a. Method f Disposition 1 Surial 2 Cremation 3 Removal from State ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cue to (or as a consequence of /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last attending physicien and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown ò 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by pe 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 🗆 Yes 1 ☐ Yes 2 10 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: Certification: To 1 Tyes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5113 MO

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of gle

Iskmo

filed (Month, Day, Year)

Greene

rd cause of death (Item 23a) (Type, Print)

32. Registras Signature

OSUI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Helen Rotruck /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3acred 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F Director 234-44-6816 Yrs. July 16,1930 West Virginia Usual Residence of Decedent be filed within 72 hours after death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 17 is marked other then "natural", or items 23s or 28s-f ehow traumatic event, the Modical Examplian towal by notified at 1 Yes 2 □ No Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 88 Ward Avenue Funeral 26726 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 2 Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk/Cashier Dept. Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Heelth and Mental Alvin R. Llewellyn Essie M. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i Chris Rotruck/Son Rt. 4, Box 69-E Keyser, WV 26726 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: if Ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 13 * 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens 2005 Keyser, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Smith Funeral Home Brian 7 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Abdomma Wall **Physician** afout (8 day /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Examine burial-translt the death certificate be executed pue Due to (or as a consequence of): physiclan by Physician/Medical the the as IF FEMALE: use Use 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery etten for u 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ninknown Completed should should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 X No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Teath 28b. Time of Certification: 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 26907 Hedm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Harsit Sidhu Bishop Walsh Road, Cumberland

State

DHMH 17 Rev 1/2001

P.O. Box 68760;

Division of Vital Records,

31. Date filed (Month, Day, Year)

Registrar's Signature _

amend item#31, per byk, C845, 7/15/05 The State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7. Time or Death Month Day **Physician** Redd PM Gary 1:20 JUL 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner Baltimone Jorden west Hospital Rundallstone حساد Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 M 2 □ F Yrs. Director Jul 31, 1958 Maryland 214-70-9975 46 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentai Hyglene. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Show rai, or itams 23a or 28a-f show Exactling must be notified at 1 Yes 2 □ No **Baltimore** Completed by Funeral Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 6611 Krone Drive 21207 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify Black 3 ☐ Widowed 4 ☐ Divorced if Health and Mental Hyglene.
item 27 is marked other than "natur
other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Auto Company Auto Mechanic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Essie Mae LeSane Luther Redd Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6611 Krone Drive Baltimore, Md. 21207 Essie Mae LeSane Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/16/05 Lansdowne, Md. * 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 21. Signature of Funeral Service I 22. Name and Address of Facility Estep Brothers Funeral Service PA 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Pulmonary resulting in death) /Medical Due to (or as a consequence of): Examiner Strace Sequentially list conditions, Due to (or as a consequence v) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit -ter Due to (o a consequence of): Box 68760. nding physician use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ icate has been sign, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 2 No 1 🗌 Yes 1 TYes the Hospitei or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Other: P 1 Yes 2 □ No 1 ☐ Inpatient 2 区ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide e Funarai dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 July 10 2005 H0055644 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a 5401 Old Govet Rd Randallstown MD Jenniterz 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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ician	Registrer 1. Decedent's Name (First, Middle, Last)		tificate of I		2. Date of Dea		3-Time of Deeph				
dical.		Deborah Ann R	awes			July 8	3 , 2005	10:35 A.				
niner	4a. Facility Name (If not institution, give				Location of Death		4c. County of	Death				
	Anne Arundel Me				polis			rundel				
al or	5. Social Security Number unk 1 M 2 X F 48 Yrs. 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 0 Ct. 30, 1956 0 re											
	Usual Residence of Decedent	10-00-					,					
7	Md. In Anne Art		Town or Loc mbrill					10d. Inside City Limi 1 ☐ Yes 21€1				
Funeral Director	10e. Street and Number	inder Gar	11101 111	10f. Zip Code			10g. Citizen of Wh					
Ö	2490 Bell Branch	Road		Tor. Zip Code	21054		USA	at Country:				
nera	11. Marital Status	12. Was Decedent Ever in U.S.	13. W	as Decedent of H	ispanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No-	14. Race -	American Indian,				
þ	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		Tes, specify Cuba	Specify:	Hican, etc.)		White etc. White				
Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Decede (Give k	ent's Usual Occupi ind of work done of O NOT use retired	ation furing most of work)	ing	16b. Kind of Busin	ness/Industry				
E O	Elementary/Secondary (0-12)	College (1-4or 5+)	_	esing gu	_		County P	olice				
Be	17: Father's Name (First, Middle, Last)			unk	18. Mother's Name	(First, Middle,	Maiden Sumame)	unl				
2	19a. Informant's Name/Relationship (T)				and Number or Rura							
	Victoria M. Rawes			Bell Bra				1and 21054				
	1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	netery, crema	atory or other plac		yate	20c. Location - Ci	ty or Town, State				
	21. Signature of Funeral Service Licens Ronald S	ade, Director	bta	Name and Addres ate Anato Ltimore,	omy Board		Baltimor	e Street				
	23a. Part1. Enter the disease, or company of the co	lications that caused the death. ne cause on each line.	Do not enter	the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death				
	disease or condition resulting in death)	a Due to (or as a consequer) (p)	1)	1000	1	<u> </u>	_				
	f .		111	10014	Truct	Intr-	Kic.					
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	nce of):				-/					
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	200 00									
icai E	d.											
9		d										
Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown		of delivery Day Year									
by Phy	Part II. Other significant conditions co	ntributing to death but not resulting	ng in the und	derlying cause give	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?				
						1 □ Y	es 2.⊡•No 31	☐ Probably 4 ☐Unknow				
et						24a. Was a		re autopsy findings availat				
<u>a</u>				-		autops perform	med? dea	r to completion of cause o th? Yes 2 □ No				
Completed	OF Men and address of the second and					(Check only on	(e)					
Be Compi	25. Was case referred to medical examiner?	examiner?										
To Be Compi	examiner?	. 1 ☐ Inpatient 2 ☐ ER	27. Many of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occur									
lon: To Be Compi	examiner? 12 Yes 2 No 27. Man of Death 1 Natural 5 Pending	. 1 ☐ Inpatient 2 ☐ ER	Bb. Time of Injury	28c. Injury Work								
fication: To Be Compi	exam/ser? 12 Yes? 2 No 27. Mann of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	Injury	M 1 🗆 Y	at ? ∕es 2 □No		reet and Number	or Rural Route Number				
ertification: To Be Compl	exam/ser? 12 Yes 2 No 27. Man of Death 1 Natural 5 Pending investigation	28a. Date of Injury 28	Injury	M 1 🗆 Y				or Rural Route Number,				
dical Certification: To Be Compl	examiner? 1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phy	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) sician: To the best of my knowle	Injury e, farm, stree	M 1 1	/es 2 □ No	28f. Location (St City or Town	n, State)	er as stated.				
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Marylan	•	ent of Health and	Mental Hygie	2000	20051
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Las Na - M 4a. Facility Name (If not institution, give	ae Sha i	ckey 1.4b. ci	y, Town, or Location of Deat	2. Date of Death Month	Day Year 9 2 2 2 2 4c. County of Dea	th
	Funeral Director		5. Social Security Number 5. Social Security Number 6. Se 9(-42-3443) 11 Usual Residence of Decedent			der 1 Year If Under 24 Hrs s Days Hours Min.	8. Date of Birth	9. Birl	timore hplace (State or Foreign buntry) ORK:
	within 72 hours atter death with the Maryland ene. than "natural", or Itema 23a or 28a-f show the Madical Examainar is ust be motified at	Director	10a. State 10b. County 10e. Street and Number	MARE 10c. Cit	y, Town or Location BAC 10f.	TIMORE Zip Code	10g	. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No buntry?
036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Deparment of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Itema 23a or 28a-1 show amy layer or other traumatic event, the Madical Evandina in the India at any layer or other traumatic event, the Madical Evandina in the India at any layer.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer 2) No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
121215-003	filed within 72 ho Hygiene. other than "natur ent, the Wedical	Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)		16a. Decedent's U (Give kind of life. DO NO1	work done during most of wo use retired)	rking 16	teath	Care
Maryland	12 should be fi h and Mental H 7 Ia marked ot traumatic ever	To Be	19a. Informant's Name/Relationship (7	himenty	19b. Mailing Addre	Be Cylass (Street and Num, er or R	1 Leach	-Lewi	S. Zip Code)
altimore, l	permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr. once.		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	Removal from State	Place of Disposition (Permetery, crematory of		13-05 F	C. Rest H	111,140
8			23a. Part1. Enter the disease, or compshock, or heart failure. List only of	slications that caused the deat one dayse on each line.	n. Do not enter the m	SFUNERACC ode of dying, such as cardia	THAPEL BE	BOHARF	Approximate Interval Between Onset and Death
	/mysician /Medical Examiner	her	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. DISSEMINA Due to (or as a conseq SEPSIS DU b. Due to (or es a conseq	juenca of): E TO FUL		ECTION	HILLI	4 DAYS
8760,	ate be executed hysician and the burial-transit	lical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. OF CL Due to (or as a conseq ABDOMINAL	juence of):	M DIFFICLE MENT SYNDRO	IME		
O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of d 9 □ Unknown	el death 3 Ectopic			23d. Date of del Month	ivery Day Year
ords, P.	requires that incensioned by hould be detailed	eted by Ph	Part II. Other significant conditions of HISTORY OF REC	TAL CANCER	sulting in the underlying	g cause given in Part I.	1 ☐ Yes	2 No 3 □ Pr	the cause of death?
ital Rec	cian: The law ertificate has t ctor, page 2 s	Be Completed	URINARY INCONT				24a. Was an autopsy performe 1 Ves 2 0 ath (Check only one)	d? 1 \(\sum \) Yes	utopsy findings available completion of cause of 2X No
Division of Vital Records, P.O.	Attending Physic or death. ector: After this co by the funeral dire	Certification; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	DOA Other: 4 Nursing H	Home 5 Residence 28d. Describe how	injury occurred	
DİX	the Hospital or Attend thin 24 hours after death the Funeral Director: , mpletely filled in by the f	Medical Certific	(Check only 2 Medical Exam	building, etc. (Special special fy) owledge, death occurr	ed at the time, date and place	28f. Location (Stree City or Town, S e, and due to the caus urred at the time, date	State) se(s) and manner as	stated.	
)	To the Parity 2.	Med	29b. Signature and title of certifier	and manner stated.	(m	29c. License number DØØ225Ø5	29d.	Date signed (Mont	h. Day, Year)
2	Sta Registr		30. Name and address of person who of the CHARLES KIM 31. Date filed (Month, Day, Year)	M. D. 760 32. Sgistrar's Signa	1 0SLER	PRIVE, TOWS	ON, MARY	LAND 21	204

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** July 8, 5:00 PM M Betty Stair 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1□M 2₩F Director Yrs. 175-24-6081 76 Jan 21, 1929 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Maryleal Examinating the notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD St. Mary's 1 ☐ Yes 2 ☑ No Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46664 Yorktown Road 20653 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Complet Elementary/Secondary (0-12) College (1-4or 5+) 12 clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Court Ambrose McCully Elizabeth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46664 Yorktown Road Leonardtown, MD Robert Stair/spouse 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☑ Donation 5 ☐ Other (Specify) S. Wade 21. Signature of Funeral Servin 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Will Baltimore, MĎ 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner renal aillire Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2000 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death Check onlone examiner' Certification: To 1 ☐ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29a. Certifier Medical completely (Check only one) action and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29b. Signature and title 29d. Date signed (Month, Day, Year) 8,2005 WI 30. Name and address of person empleted cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2005 15 Registrar

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment rtificate			nd M		giene Reg. No. 7	0 0	
	Physici	an	Decedent's Name (First, Middle, Last	•						2. Date of Dea Month	ath Day	Year	Zrime ZDean 6
	/Medic Examir		Hunter 4a. Facility Name (If not institution, give	R.		tle,		Location of	Doath	July	12, 21	005	5:45 A M
	Exami	lei	7 Edgemoor Ro					ille	Death			imor	
	Funeral		5. Social Security Number 6. Si	9x 7. Ag	e (In yrs. last birthday)	If Under	1 Year	If Under 2		8. Date of Birth	h		place (State or Foreign ntry)
	Director		216-18-3183	X ^{M 2□ F} 8	34 Yrs.	Months	Days	Hours	Min.	10/8/19	20	Mar	y land
	pug .		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	cation							
	sho	ក	,									}	10d. Inside City Limits
	tha N 28a-f	Director	Maryland Baltimo	re	Luthervi		0.1						1 ☐ Yes 2 ☐ No
	within 72 hours after death with the Maryland ane. then "netural; or items 23a or 28a-f show ta Madical Exercit at most be notified at	Ö	7 Edgemoor Ro	ad		10f. Zip (093				10g. Citizen of \	What Cou	ntry?
	leath	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S. 13			enania Origi	in2 (Cnn	cify Yes or No-	USA	Amari	can Indian.
(0	r iten	Fun	1 ☐ Never Married 2 Married	Armed Forces?	No	t Yes, speci	ty Cubar	n, Mexican,	Puerto F	Rican, etc.)		k, White,	
99	urs a	by	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ I If Yes, Give Year or Dates:		1□Yes 2	□ X No	Specify:			Specify	· Wh	ite
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nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)					18. Mother	s Name	(First, Middle,	Maiden Surnam	18)	
<u>yla</u>	2 should be and Mental is markad raumatic ev	To	Hunter R.	Shettle,				Ire		Pri			
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "netural; or items 23a or 28a-f show or other traumatic event, it a Madical Exact		19a. Informant's Name/Relationship (7	• • • •	_						r, City or Town,		
	is 1 and 2 of Health a item 27 is other trau		Margaret Mary Sho	ettle / Wi		dgemod					, Maryl		
Baltimore,	if of h		1 XBurial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, crer						20c. Location -	City or To	own, State
Ħ	t. Pa rtmer rtant rjury		'4 □Donation 5 □ Other (Specify	1	Gardens				7/15,	/05	Overlea		
Bal	permit. Pages 1 am Deportment of Heal Important: if item 2 any injury or other once.		21. Signature of Funeral 5 vice Lice	388		. Name and					10	50 Yo	ork Road
			232 Part 1 Enter the discuss or fame	Cery!	K the death Death	uck ic	OWSOI	1 Fune	erai	Home,	Inc. lo	wson,	Md.21204
ı	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
п	Examiner			Due to (or as	a consequence of):							7	Months
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oʻ	e exe ian ai urial-t	EX	resulting in death) Last	Due to (or as	a consequence of):								
8760,	cate be executed physician and the burial-transit	dicai	(d									
9	entific ling p	0	IF FEMALE:									- [
Вох	death certific e attending p od for use as	ian/	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal death 3 ☐	Ectopic pre					23d. Date Mor	e of delive	ry Day Year
o.	000	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death 5	Other (spec	cify)				11101		Day Toal
a	res that the d ignad by the be detached	by Physician/M	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the ur	deriving ca	ISA CIVAR	n in Part I		23e Did tot	pacco use contr	ibute to th	e cause of death?
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Vital		e ·	25. Was case referred to medical					ac Blass	(Death	(Check only/on		Yes	2□ No
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סר	문 등 교	n: T	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time of		c. Injury a Work?				w injury occurre		/
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Division	i or Atte after de Directo	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, farm, stre	et, factory,	office		28	3f. Location (St. City or Town	reet and Numbe	or Or Rura	Route Number,
	itel o irs afi rel Di	O		0	(=,, -,						, 0.0.0)		
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	ledicai	29a. Certifier (Check only one) Certifying Phy	sician: To he best of ner: Of the basis of and matther sta	of my knowledge, death examination and/or inv ted.	occurred at estigation, ir	the time n my opii	, date and p nion, death	place, ar occurred	nd due to the ca	use(s) and mar ate and place, a	nner as st nd due to	ated. the cause(s)
	5 # 5 P	Σ	29b. Signardre Mt title Certifier	11/1/		29c. I	License	number	0	25	9d. Date signed	(Month	Day, Year)
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	Star Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	ede							

		1 _ For	State of Maryland /			ıtal Hygier	те	
		Registrar		Certificate of I		Reg. N	2005	23257
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/Medic Examir		4a. Facility Name (If not institution, gi		4b. City. Town, or	Location of Death	/ //	4c. County of Deatl	
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Funeral			Sex 7. Age (In yrs. last bi		If Under 24 Hrs. 8. [Date of Birth (Month, Day, Yea	9. Birth	hplace (State or Foreign untry)
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land ow		10a. State 10b. County	10c. City, Tov	vn or Location				10d. Inside City Limits
Mary 1-f sh	tor	Pena	al Tri	nidad W.I	- -			1 ☐ Yes 2 No
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death with the Maryland ms 23a or 28a-f show frust be notified at	ral	222 Lachoos	Road	none		Tr	inidad	& Tobago
er dea Items	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify In, Mexican, Puerto Rica	Yes or No- in, etc.)	14. Race - Ame Black, White	
5-UU30 72 hours after natural; or Ite	by F	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1□ Yes 2□No	Specify:		Specify: Trj	nidadian
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yiand butd be fit Mental H arked ott attic even	Be	17. Father's Name (First, Middle, Las	marine Choudari	io	18. Mother's Name (Fin			
should Ind Men In marke	၀	19a. Informant's Name/Relationship		b. Mailing Address (Street a	Tillarie			Tip Code)
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of Health		20a. Method of Disposition	20b. Place of	of Disposition (Name of ery, crematory or other place	Date	20c.	Location - City or	Town, State
Pages nent of ant: If It		1 ☐ Burial 2 ☐ Cremation 3√ 1 ☐ Donation 5 ☐ Other (Spec	Cana 1	«Cemetery	7/22/	/05 P	enal Tr	inidad WI
Dalitimol permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Lice	insec?	22. Name and Addres	Conr			meofEssex
		23a. Part1. Enter the disease or conshock, or heart failure. List only	inplications that caused the death Do	not enter the mode of dying	ce Ave. Ba g, such as cardiac or res		e MD ZI	Approximate
_Physician		Immediate Cause (Final disease or condition	_aArteriosclero	TraCardiana	andon D	1505	0	Interval Between Onset and Death
/Medical		resulting in death)	Due to (or as a consequence		Szalav	- 2		10 years
Examiner		Sequentially list conditions,	b. —————					
bed isit	Examiner	Sequentially list conditions, if any, issuing to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	en:				
xecut al-trar	xan	that initiated events resulting in death) Last	c	of):	······································			
ificate be executed physician and as the burial-transit			d					
J =	ledical		0.					
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	a 3 □Ectopic pregnancy		,	23d. Date of deli	
that the death cered by the attendir detached for use	slci	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of death 9□Unknown	5 Other (specify)			Month	Day Year
hat th d by detach	Phy	9 Unknown	contributing to death but not resulting i	in the condent increase access	on in Donal	22a Did tabasa	a transporteibrate to	the cause of death?
uires tha	d by	Tarris, other agrittonia conditions	contributing to death but not resulting i	in the underlying cause give	silli Fait I.		2 □ No 3 □ Pro	
w require been si should t	ompleted							
he lav e has ige 2 :	dmo					24a. Was an autopsy performed?	prior to c death?	topsy findings available completion of cause of
	e C	25. Was case referred to medical			26. Place of Death (Ch	1 Yes 2 N	Vo 1 ☐ Yes	2 No
Of VIGAL THE IS Physicien: The Is rethis certificate hairestor, page 2	To B	examiner? Yes 2 No	Hospital: 1 Inpatient 2 ER/Ou	utpatient 3 DOA Othe			6 ☐Other (Spec	ufy)
ding Ph After th funeral		27. Manner of Death		Time of 28c. Injury		Describe how in		
eath. or: A	catle	2 Accident investigation	on		Yes 2□No			
or Att	Certification	3 Suicide 6 Could not to determined		arm, street, factory, office		Location (Street a City or Town, Sta	and Number or Rui ite)	ral Route Number,
Division: Vitality Hysicien: win 44 hours after death the Funeral Director; After this certification in by the funeral director,		29a. Certifier 1☐ Certifying P	hysician: To the best of my knowledge	a dooth conversed at the time	and date and place and a	due to the course	(a) and manages	
• Hos 124 h • Fur letely	edical		miner: On the basis of examination an and manner stated.	nd/or investigation, in my op	pinion, death occurred at	the time, date a	nd place, and due	to the cause(s)
To the Hospitel or Atlandi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	. X t	29c. License			Date signed (Month	
		I shill white M	1 Deputy	DIS	667	Ju	ly 13.2	2005
	ľ		completed cause of death (Item 23a)	DIS ble H:11 CT	- , tl	~1/ A	1 -	0.7
O			LO, MD GTrim	ple H:11 C1	. Luthonu	"116 1	19 510	243
Stat Registra		31. Date filed (Month, Day, Year) JUL 1 5 200	2. Registrar's Signature	house &		ο,		191
nogio:		JUL I 9 ZM	S phylling 15 for					

			For	State of Maryland / D	Departme	nt of Health and I	Mental Hygi	ene	
			1 - State Registrar		Certifica	te of Death	Re	g. No2 11 15	22250
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	hay Year	G. Timefor Dealth)
-	/Medic		GENEVIEVE	SPARKS		T	July 1	2,2005	9.30 M
1	Examin	er	4a. Facility Name (If not institution, give s	treet and number)	4b. City	Town, or Location of Death		4c. County of Death	10
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir		er 1 Year If Under 24 Hrs.		9. Birth	pplace (State or Foreign
	Director		217-24-3227 10	M 20 73	Yrs. Months	Days Hours Min.	Jan Day	932 MZ	iry and
	pug &		Usual Residence of Decedent 10a, State 10b, County	10c. City, Tow	n or Location			,	10d. Inside City Limits
	Aaryla f sho	ō	Martal All A	1 1	odla	14/10			1 No 2 No
	28e-	Director	10e. Street and Number	1 1/40		p Code	10	g. Citizen of What Cou	untry?
	h with		5501 A Wes	+ North AV	10	2/207		11 <a< td=""><td></td></a<>	
	ems ems	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was Deci	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race · Amer Black, White	
36	s afte	by Ft	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give	1 ☐ Yes			Specify: D	Call
21215-0036	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show aleal Examiner must be notified at		15. Decedent's Educ	Year or Dates:	Decedent's Usi	ual Occupation	1	6b. Kind of Business/li	acr
215	within 72 ene. then "na	plet	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of w life. DO NOT	ork done during most of wor	king		, 00
	e filed within al Hygiene. other then ' vent, ir e Ma	Completed	10		SSIST		< !	Salto.Cou	nty P.S.
ng	be fill tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	T.V.		18. Mother's Nar	ne (First, Middle, M	aiden Sumame))
Maryland	d Ment d Ment narke natic	ို	19a. Inf ant's Name/Relationship (Type	ey Deskin	_	is (Street and Number or Ru	ural Boute Number	City or Town State Zi	in Code)
Ma	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "naturel; or items 23e or 28e-1 show or other freumatic event. It is Micheal Examinat must be notified at		MsMarlana	FOX daughter) 196	22 A	ranne 7	Drive i	Rollo M	1 21218
re,	of Health item 27 other tr		20a. Method of Disposition	comoto	Disposition (Na ry, crematory or	other place) - /		Oc. Location - City or T	own, State
Ē	Pages nent of I snt: If its ury or o		1 Burial 2 ☐ Cremation 3 ☐ Re 1 Donation 5 ☐ Other (Specify)	emoval from State	ison	Forest 7/2	2/2005 (Winas M	ills. Md.
Baltimore,	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service License	VID.	22. Name a	nd Address of Facility	ineralt	tome, P.A.	11
_	205 g g		Joseph C	L. Muss	2222	W. North Ave	· Baito	14101 2 21	0
				cations that caused the death. Do not be cause at each line.	not enter the mo	de or dying, such as cardiad	or respiratory arres	St,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	LULMONN		WB OSHZ.			
	Examiner		AND THE PROPERTY OF STATE AND STATE	Due to (or as a consequence	01):	Venous	THROM	212001	
		ner	if any, leading to immediate	Due to for as a consequence	The state of the s		CITIAN	10000	
V	acuted ind transi	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	METASTAT		ERVICAL C	AHCER .	TO BLAD	OER.
60,	ficate be executed physician and sthe burial-transit	EX	resulting in death) Last	Due to (or as a consequence	of):				
38760,	icate l physi s the b	dical	d						
Box (eath certifi attending I for use as	/We	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregnancy				23d. Date of delik	very
	0 0 0	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 □Ectopic p 5 □ Other (s			Month	Day Year
P.0	at the de by the stached	hys	9 Unknown	9□ Unknown					
	The law requires that the tee has been signed by the bage 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlying	cause given in Part I.		acco use contribute to	
0.0	w require been sig should b	eted							/
of Vital Records,	The faw cate has b page 2 s	ompleted					24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
<u></u>		e Co	25. Was case referred to medical			OC Place of Pou		No 1 □ Yes	2 X No
Š	Physicien: this certific ral director,	0 B	ayaminar?	ospital: 1 Ninpatient 2 ER/Ou	itpatient 3 🗆 🗅	Other		nce 6 Other (Speci	(fy)
		n: T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury 28b.		28c. Injury at Work?	28d. Describe hov		
Siol	Vttendir death. ctor: Af y the fu	catic	2 Accident investigation		М	1 ☐ Yes 2 ☐ No			
Division	of or Attend after death Director: / d in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	irm, street, facto	ry, office	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	spitel ours a nerel [29a. Certifier 1 X Certifying Phys	ician: To the best of my knowledge	a. death occurre	at the time, date and place	and due to the car	ise(s) and manner as	stated
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical		er: On the basis of examination an and manner stated.	d/or investigatio	n, in my opinion, death occu	rred at the time, dai	te and place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	20 11		c. License number	29	d. Date signed (Month)	, Day, Year)
)			Da Singa 1 3	m-ella m.o	>	D41410	7	uly 12th,	2005.
	6		30. Name and address of person who con	0		JOGIMOER	P MEHTI	7	
	<i></i>		31. Date filed (Month, Day, Year)	2. Registrar's Signature	ER 1	LAHOAUS TO	WH ME	> 31133) .
90	Sta Registi		JUL 1 5 2005	32. Registrar's Signature	Ships of				

			State of Maryland / Depar	rtment of Health and M	-	•						
				rificate of Death		. No.2 0 0 5	22200					
	Physici		Decedent's Name (First, Middle, Last) LEON SAULS		2. Date of Death 7 / 6 / 05	Day Year	8:40 PM					
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death						
			(HOME) 6611 KRONE DR.	BALTIMORE		Baltimore						
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $^{\circ}$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	ear) 9. Birthplac Country	e (State or Foreign) . C .					
	D D		Usual Residence of Decedent		7/9/09	11						
	show	or	10a. State 10b. County 10c. City, Town or Loca MD. Baltimore BALT	ation 'IMORE		10d.	Inside City Limits 1 ▼ Yes 2 □ No					
	the N	rect	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country						
	th with	al Di	6611 KRONE DR.	21207		USA						
	er dea	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. W.	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Black, White, etc						
936	urs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X ☐ No If Yes, Give 1 ☐ Year or Dates:	☐ Yes X☐ No Specify:		Specify: BL	ACK					
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-1 show the Medical Examiner mast be notified at	Completed by Funeral Director	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give ki	ent's Usual Occupation ind of work done during most of worki O NOT use retired)	ing 16i	b. Kind of Business/Indus	try					
121	filed within Hygiene. Sther than '	ompi	Elementary/Secondary (0-12) College (1-4or 5+) LONG	O NOT use retired) SHOREMAN		WATER FROM	NT					
	e filed Il Hygie other vant, I	Be Co		18. Mother's Name	(First, Middle, Mai							
ylar	should be and Mental armarked o	To	JOHN SAULS		NINITY	SAULS						
Maryland	C1 00 00 00			Address (Street and Number or Rura KRONE DR. BAL	il Route Number, C ${ m TIMORE}$.	•	_ `					
	s 1 and if Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposit			c. Location - City or Town						
Baltimore,	Ly and Pa			Cemetery 7/16	/2005 La	ansdowne,	Marylan					
Balt	permit. Pages 1 and Department of Health Important: If item 27 any njury or other tr once.		21. Signature of Buneral Service Licensee 22. ES	1300 EUTAV	V PL.							
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Artheros clerotic Vascular disease									
68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dicai Examiner	d	1510N								
O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Da	y Year					
rds, P	w requires that been signed should be del			dentying cause given in Part I.		co use contribute to the c	eause of death? y 4 Unknown					
Records,	The law rec te has bee age 2 shor	Completed by	Age related debil	lity. I	24a. Was an autopsy performer	24b. Were autopsy prior to compl death?	etion of cause of					
Vital	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical	26. Place of Death		7.0						
of	ding Phyaiclan: After this certifications of the director,	: To		3 ☐ DOA Other: 4 ☐ Nursing Hor 28c. Injury at	me 5 Residence 28d. Describe how	e 6 Other (Specify)	·					
ion	Attending or death. ector: After by the fune	ation	1 → Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 Yes 2 No		injury ossumod						
Division	or Attendiater death. Director: A in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Re State)	oute Number,					
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: Atter this certificate his completely filled in by the funeral director, page	Medical C		occurred at the time, date and place, a stigation, in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as state and place, and due to the	d. e cause(s)					
	To th within To th	Me	29b. Signature and title of certifier O - Caway Man M-D	29c. License number	14 O	Date signed (Month, Day 7-12-2	, Year)					
1,	3		30. Name and address of person who complete cause of death (Item 23a) (Type, Pr	rint) 5310 of Randallis	b CTR	D. # 305	2					
	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 5 2005 32. Redistrar's Signatures	porte	(0011)	1111 2110	·					

DHMH 17 Rev 1/2001

		ļ	1 - For State Registrar	State of Mary		artment of F			iene 99. No 200	5 2326L
	Physici	20	Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	/Medic			le Scarff				July 9,	2005	9:30 A M
	Examir	ier	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or		th	4c. County of I	
			2500 Rocks Road			Forest F				ford
	Funeral Director		5. Social Security Number 217–16–7459 Usual Residence of Decedent	M 2□F	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			Birthplace (State or Foreign Country) Maryland
	land w		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary	jo	Maryland Harford	3	Forest	**** 1 1				1 ☐ Yes 21 No
	288	Director	Maryland Harford 10e. Street and Number	<u>. </u>	rorest	10f. Zip Code		10	Og. Citizen of Wha	it Country?
	3a ol		2500 Rocks Road			210	150		USA	
	death ms 2	Funeral		12. Was Decedent Ever	in U.S. 13.	Was Decedent of H		Specify Yes or No-	14. Race	American Indian,
920	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show Joan Exambra fromst be colificated	by	1 ☐ Never Married 24 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? ↑ Yes 2 □ No If Yes, Give Year or Dates:		if Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	rto Rican, etc.)	Specify:	White, etc. White
21215-0036	_ = 10	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	durina most of wo	orking	16b. Kind of Busin	
212	d within jiene. r than "	Ho	Elementary/Secondary (0-12)	College (1-4or 5+)	Elect	ric Super	visor		Utility	Company
	e filed Il Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle, M		001.17
a		To B	Harry Everett :	Scarff			Ella I	Elizabeth	Treakle	9
Maryland	nd 2 suith ar		19a. Informant's Name/Relationship (Type Esther G. Scarff					oral Route Number, est Hill,		
Ē,	- ± = ±		20a. Method of Disposition		Ob. Place of Dispo	osition (Name of matory or other place	ca)	Date 2	20c. Location - Cit	y or Town, State
Ë			1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	Service (1-05	Towson, 1	Maryland
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service License	Ema 1		2. Name and Address CCOMAS FU			don Mars	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	death. Do not ent	er the mode of dyin	g, such as cardia	or respiratory arre	ist,	Approximate Interval Between Onset and Death 3 Years
8760,	ate be executed only sician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
O. Box 6	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p. 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
ds, P	es the	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.		_	te to the cause of death? Probably 4 Dunknown
Il Records,	The ate h page	Completed						24a. Was ar autopsy perform 1 🗆 Yes 2	/ prior	e autopsy findings available to completion of cause of h? Yes 2 \sum No
Vital	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	a onital:				ath (Check only one		
of	Physi this c al dire	P.	TE TOS ZENO	ospital:	2 ER/Outpatier	nt 3□ DOA Oth	er: 4 Nursing I	Home 5 Reside		Specify)
		on:	27. Manner of Death 1 Patural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	Worl		28d. Describe ho	w injury occurred	
Division	of or Attending after death. Director: After din by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · building, etc. (S	At home, farm, str pecify)		Yes 2 □ No	28f. Location (Str City or Town		r Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical Ce	(Check only 2 Medical Examin	ician: To the best of more: On the basis of exa	y knowledge, deat	h occurred at the tim	ne, date and plac	e, and due to the ca	use(s) and manne	r as stated.
	To the h within 24 To the F complete	Medi	one)	and manner stated.						
)	or V	2	29b. Signature and title of certifier	M	. O.	29c. License			od. Date signed (M	
)	044		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	Print) Lwood	Road.	# 200 , £	Bel Air,	, MDZ1014
	Sta Registi		31. Date filed (Month, Pay Year) 5 21	32. P distrar's	Signature	haut's				

			1 - State of Maryla	-	artment of He			ene	•
	Physici		1. Decedent's Name (First, Middle, Last) Hsiang Lin Tang				2. Date of Death Month		2. The A Gath 2
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	ocation of Death	Jung	4c. County of D	
			5006 Dorothy Field Road		Perry H			Balti	nore
	Funeral Director		5. Social Security Number 113-50-4102 Usual Residence of Decedent 6. Sex 1 □ M 2 ☑ F 7. Age (In yr. 94)	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, June 19,	Year) 9. 1	Birthplace (State or Foreign Country) LUNA
	anyland ahow	٥٢	10a. State 10b. County 10c. (City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N	Director	Maryland Baltimore	rev	10f. Zip Code		10	g. Citizen of What	
	3a or	Ö	5006 Dorothy Field Road			1128		U.S.	
ဖွ	J within 72 hours after death with the Maryland jiele. Tele Madical Extra investigation of 28e-1 ahow The Madical Extra investigation of	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in Armed Forces? 1 Yes 2 M No If Yes, Sive		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🕱 No		cify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian,
-003	2 hours atural', cal Ext	ted by	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education	16a. Dece	dent's Usual Occupat	ion	1	6b. Kind of Busine	
Maryland 21215-0036	I within jene. r than "	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+)	life.	kind of work done di. DO NOT use retired) Omemaker	ıring most of workii	ng	Own Hoi	,
land	buld be filed Mental Hygis arkad other etic avant, I	ro Be C	17. Father's Name (First, Middle, Last) Hsin Yuan Lu			18. Mother's Name Chu Lu	(First, Middle, Mi	aiden Sumame)	
	d 2 shu th and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print) Mr. Sherman Tang (son)		ng Address (Street ar 6 Dorothy				
nore,	Pages 1 and neut of Healt out: If item 2 iry or other				sition (Name of matory or other place) Crematory			Oc. Location - City	or Town, State Maryland
Baltimore,	permit. Pages Department of I Importent: If its any injury or or		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses	22	2. Name and Address	of Facility Sch	imunek F	uneral H	omes
	æ		23a. Part1. Enter the disease, or complications that caused the de		9705 Belai er the mode of dying,				Approximate
	Physician /Medical	and a	snock, of heart failure. List only one cause on each line.						Interval Between Onset and Death 7 a MS
	Examiner	ie.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a const	ereb	ardiai Vovasci	ulai c	recidei	it	11 days
ti	be executed sician and burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a constitution of the constitutio	equence of):					
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Division	r Attanoter death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At building, etc. (Spe	home, farm, str		es 2 □No	28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
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	To the within 2 To the complet	Med	one) and manner stated. 29b. Signature and title of certifier		29c. License	number		d. Date signed (Mo	
	4		30. Name and orders of person who completed cause of death (It	ЭИ, М ет 23a) (Туре.		56623		July 15	5,2005
	1		Jin Gu, MD, 7505 Os	er Dr	. Suite4	03, To	WSOn,	MD 2	1204
1	Sta Registi	-	31. Date filed (Month, Day, Year) 32. Resistrar's Sig	M M	boots				

		1 - For State Registrar	State of Maryland	-	rtment of He crificate of L			ene • NºO O O '	
Physic /Med		1. Decedent's Name (First, Middle, Last) Ed Wourd			Taylor		2. Date of Death	3 ^{Day} 2005	SILA W
Exam	iner	4a. Facility Name (If not institution, give st Macu Hed	reet and number)	tes	4b. City, Town, or Rad	Location of Death		4c. County of Di	eath
Funera Directo		251-18-1253	7. Age (In yrs. Ii M 2 F 79	ast birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Apr 25,	^(ear) 1926 Sc	Birthplace (State or Foreign Country) outh Carolina
aryland show	_	Usual Residence of Decedent 10a. State 10b. County		, Town or Loc					10d. Inside City Limits
th the Mi	Directo	MD 10e. Street and Number		Baltimo	10f. Zip Code		109	g. Citizen of What	1 √ Yes 2 □ No Country?
death w	Funeral	1027 Cathedral St	2. Was Decedent Ever in U.	S. 13. W	21202 as Decedent of His Yes, specify Cubar		ecify Yes or No-	USA 14. Race - A	merican Indian,
5-UU36 72 hours after death with the Maryland naturel; or Itams 23a or 28a-1 show alea Extra itret is ust be rediffed at	þ	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:		Yes, specify Cubar □ Yes 2) No	Specify:	Rican, etc.)	Black, W Specify: 1	
within 72 hours ene. than "naturel", the Medical Ext	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Decede (Give k life. D	ent's Usual Occupa ind of work done d O NOT use retired)	tion uring most of worki	ing 16	6b. Kind of Busine	ss/Industry
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Mith a		19a. Informant's Name/Relationship (Type Dorothy Pressley/s	. ,		Address <i>(Street</i> a 8 Wayne <i>A</i>				
or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☒ Donation 5 ☐ Other (Specify)	1 0	lace of Dispos emetery, crem	ition (Name of atory or other place	e) [Date 20	c. Location - City	or Town, State
baltim permit. Pag Department Important: any injury		21. Signaydre Thi neral Spice License Ona I S W	ade Director	St.	Name and Address ate Anato ltimore,	s of Facility omy Board	655 W. I	Baltimore	Street
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_ <u> </u>	b	Part II. Other significant conditions conf	ributing to death but not resu	ulting in the un-	derlying cause give	n in Part I.			to the cause of death?
The law ate has to page 2 s	Completed						24a. Was an autopsy performe	prior t	
Of VITAL Physicien: 1 this certifical al director, p	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 No	ospital:	ER/Outpatient	3□ DOA Cthe	6	n (Check only one) me 5 ☐ Residen		pecify)
ng ng wither wither name		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injury Work M 1 [] Y	at ? ′es 2 □ No	28d. Describe how	injury occurred	
E Sign	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
To the Hospital or within 24 hours affe To the Funerel Dir completely filled in	Medical	29a. Certifier 1 Certifying Physical Check only one) 1 Certifying Physical Exemination (Check only one)	cien: To the best of my known. On the basis of examinat and manner stated.	wledge, death tion and/or inve	occurred at the time estigation, in my op	e, date and place, inion, death occurr	and due to the cau ed at the time, date	se(s) and manner e and place, and d	as stated. lue to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	4),		29c. License			d. Date signed (Mo	
		30. Na and address of person who cor	nple cause of death (em	23a) (Type, F	rint) Stral Co	10 444	201 0	uly 5,	2001 Il Place JUD 21202
	tate	K.A. Kor ricle, 10	Mucu 32. Registrar's Signal	Me He	exal Co	uses	Ba	briery	MD 21202
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Please Type or Print in Black Indeligious Lensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. July of Death Decedent's Name (First, Middle, Last) Physician JUNE 11, 2005 2:30 A. DANIEL RICHARD TIMON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE 1 AUREL 7002 SCOTCH DRIVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG. 19, 1956 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 48 Yrs MAINE Director 006-62-3387 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner rount be notified at M⊠Yes 2 No Director MD PRINCE GEORGE LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 20707 IISA 7002 SCOTCH DRIVE permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If tiem 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 N Married 1 Yes 2 No WHITE Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MULTI MEDIA ANALYST NAT'L ACADEMY OF SCIENCE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LILLIAN GENEVIEVE DOWNES ROBERT LOUIS TIMON, SR. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7002 SCOTCH DRIVE, LAUREL, MARYLAND 20707 REBECCA J. TIMON / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-14-05 BALT/WASH CREMATORY LAUREL, MARYLAND ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707 u 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sman Ky Squamous cell cercinone of the oropheryns Pnysician 4005 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncorpy g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): 68760 nding physician Physician/Medical Box (IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year j Day 5 Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 9 Unknown à ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To his 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 \ Homicide 24 hours 8 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 D39639 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 22 S. Greene B ZIMAN WD 2. Registrar's Signature 31. Date filed (Month, Day, Year) boarde State 5 2005 Registrar 1111

State of Maryland / Department of Health and Mental Hygiene

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	177		Mary Beth Bradshaw-Pruitt 306 W. Main Street - Crisfield, MD 21817												
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TAYLOR, ARTEMEAS DOB SIISTIS 218-16-7033 Baltimore. Marvland 21215-0036 700 1930 Division of Vital Records. P.O. Box 68760.

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To To To To	Σ	29b. Signature and title of certifier	* ~	29c. License number	er	29d.	Date signed (Month	, Day, Year)
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H		30. Name and aderess of person who completed cause of de	eath (Item 23a) (Type.	29c. License number DS6317 Print) Berlin, M Specific	1) 218	11 Gre	gory ST.	amous, MD
Sta Registi	43	31. Date filed (Month, Day, Year) - 32. Registration 15 2005	As Signature	Sperle				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 13, **Physician** Jordan Frank Truitt /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 11 Arkla Court Catonsville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 🖫 M 2 🗆 F 219-32-0981 Yrs. 69 Director Oct. 6,1935 Maryland Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28e-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or items 23a 11 Arkla Court 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Armed Forces:
1 XYes 2 No
If Yes, Give
Year or Dates: 1959-61 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrical Production_Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Weldon F. Truitt Mae A. Bird 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua B. Towson Cousin 4 David Lee Court; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Druid Ridge Cemetery 7/15/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Pikesville, Maryland 21. Signature of Funeral Service Lightse 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 1010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** MONTH resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) been signed by the a should be detached t ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 4 SUnknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed certificate 2 or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 1 Yes 2 No 27. Manner of eath Certification: To Other: 4 Nursing Home Sy Residence 6 Other (Specify) 3 DOA this 28d. escribe how injury occurred completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Tothe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifis 29c. License number 16354 30. Name and address of person who completed cause of death (Item) (Type, Print) 100 ATON AVE BALTIMORE MO DLE GNES 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 5 2005

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7 D5036 7		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		21,205
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State Registrar 31. Date filed (Month, Day Year) 32. Registrar's Signature		

			For State	State of Maryland		artment of H			0000	
			Registrar 1. Decedent's Name (First, Middle, Last	1	Cer	unicate of L	Jealli	2. Date of Death	. No.2 0 0 5	23269
Pi	nysicia	an				Moodynad	MD	Month	Day Year 2005	G-AF A M
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eath	2 E	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. \			Specify Yes or No-	14. Race - Americ	an Indian.
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d 21215-0036 filed within 72 hours after death with the Maryland Hygiene,	ovent, the Medical Exeminer must be nutified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I∐ Yes 2⊠ No	Specify:		Specify: Whi	te
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Taryla 2 should and Men	other treumetic		19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailir	g Address (Street a	nd Number or F	lural Route Number, C	ity or Town, State, Zip	Code)
1 and 2 Health	ner tre		Celeste Applefel				Way, Ba	Itimore, M		
O CE	- b-		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	cen	etery, crer.	sition (Name of natory or other place	9)		c. Location - City or To	
Pages tment of the	Jury		* 4 ☐ Donation 5 ☐ Other (Specify,	meaut		anch Ceme		7/14/2005	Westmins	ster, MD.
Departition	any injury o		21. Signatur o Furiera Service Licens	S. Coster		. Name and Addres			n Funeral land 2120	
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	director, pag	Be	25. Was case referred to medical examiner?				26. Place of De	eath (Check only one)	-1	()
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in 24 h	T @	edical	(Check only 2 Medical Examone)	iner: On the basis of examinatio and manner stated.	n and/or in	vestigation, in my op	pinion, death occ	urred at the time, date	and place, and due to	the cause(s)
To the within 2	complai	Σ	29b. Signature and title of certifier	(10) , 171	11 *	29c. License		29d	. Date signed (Month, I	Day, Year)
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10%	1		30. Name and address of person who o	ompleted cause of death (Item 2	3a) (Type	Print)	l Center	Bultin	ino mi	19 212 01
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	iter death with the Marylan r itema 23a or 28a-f show	Director	MD Harford	Н	avre d	e Grace						
	or 2	Oire	10e. Street and Number			10f. Zip Code			10	0g. Citizen	of What Cou	ntry?
	th w 23a		750 Tydings Road			21078				USA	\	
	dea	Funerai		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origi	in? (Specify	Yes or No-	14.	Race - Ameri Black, White,	
9	or ite		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 X No	Specify:		,,	6-		
င္ထ	n 72 hours after death with the Maryland "natural", or itema 23a or 28a-f show edical Ever their must be notified at	by	3 Widowed 4 Divorced	Year or Dates:		12 100 2410	Openy.			36	ecify: Wł	nite
20	72 ho	tec	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual Occup	ation	of working		16b. Kind	of Business/In	ndustry
2	c * 3	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	og				
21215-0036	filed with Hygiene. Ither than	Completed	12th		Н	omemake	r			Ho	me	
	be filed within tal Hygiene. d other than 'event, the Ma	Be (17. Father's Name (First, Middle, Last)				18. Mother	's Name (Fi	irst, Middle, N	Maiden Su	mame)	
<u>a</u>		ToE	William Horton				Anı	na Jo	nes			
Maryland	12 should be fi h and Mental H 7 Is marked ott traumatic ever	-	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address (Street				City or To	own, State, Zij	p Code)
Š	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		David Wilson- Hush	oand	750	Tydings	Road	Havr	e de (Grace	MD.	21078
Baltimore,	ss 1 and 2 of Health item 27 I		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place		Date			ion - City or T	
<u></u>	0 0		1 X Burial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)		•	•	. 1	7/19/	0E /	\ h =	daan 1	MD
Ē	rtan njun		21. Signature of Funeral Service Licens			Mem. Gro			U5 F	Aberc	deen, M	VID
Ba	permit. Pag Depintment Important: I any injury o		21. Signature of Fulleral Service Licens		→ Mi	tchell-Sm 3 S. Was	ŋith Fi	unera	I Home	, P.	Α	1D 04070
-	462.00	- 9	Julaine 11). Druck			_				race, N	AD 21078 Approximate
		10	23a Part1. Enter the disease, or compleshock, or heart failure. List only or	ne cause on each line.	ath. Do not en	ter the mode or dylr	ig, such as c	ardiac or re	spiratory arre	3 51,		Interval Between Onset and Death
1	Pnysician	6 0	Immediate Cause (Final disease or condition	Sepsis							-	four days
	/Medical		resulting in death)	Due to (or as a conse	equence of):							12
	Examiner		Sequentially list conditions,	Funger	lia							are weekle
		ner	if any, leading to immediate	Due to (or as bonse	equence of):							
0	cuted nd ransi	Examin	cause. Enter Underlying Cause (Disease of Injury) that initiated events	· Perituri	175							two weeks
o,	an ar rial-t	EX	resulting in death) Last	Due to (or as a conse	equence of):							
8760,	cate be executed physician and the burial-transit	dicai		d								
68	g ph as th	edi								-		
Вох	ndin	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		76				23d	d. Date of deliv	very
m	death atte	cia	in the past 12 months? 1 Yes 2 No	1□Live birth 2□Fe 4□Pregnant at time of		□Ectopic pregnancy □ Other (specify) _	y 				Month	Day Year
P.O.	the c y the	ıysi	9 Unknown	9□ Unknown								
	The law requires that the death certific that has been signed by the attending prage 2 should be detached for use as	by Physician/Me	Part II. Other significent conditions co	ntributing to death but not re	esulting in the u	underlying cause giv	en in Part I.		23e. Did tol	oacco use	contribute to	the cause of death?
Records,	sign d be	qp	Crustonic Li	ver Circhesi	Z				1 □ Ye	s 2 🗆 N	No 3∏Pro	bably 4 🚈 Unknown
Ö	w require been sig should b	Completed	31						04- 146	- To	14h 18/0	anno findinan available
ec	e 2 s	npi							24a. Was a autops perforr	y ned?	prior to co	opsy findings available ompletion of cause of
<u> </u>		Ö							1 ☐ Yes 2	2. No		2 No
Vital	ysician: This certificate director, pag	Be	25. Was case referred to medical examiner?					of Death (C	Check only on	Θ)		
of V	09 U =	2	1 ☐ Yes 2 🛣 No		☐ ER/Outpatie	III JUDON		rsing Home	5 🗆 Reside	ence 6	Other (Speci	ify)
0	ding Phy h. After thi tuneral	ü.	27. Manner of Death 1 ➤ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur	ry at rk?	280	I. Describe ho	ow injury o	ccurred	
Ö	ath. or: Al	atic	2 Accident investigation			M 1 🗆	Yes 2□N	No				
Division	ai or Attending F s after death. ii Director: After ed in by the funers	tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, factory, office		28f.	. Location (St City or Town		Vumber or Rui	al Route Number,
Ō	s afte	Cer		Danemaj eta (apa	,,				,	, , ,		
	hour hour mere y fille	ai (29a. Certifier Certifying Phy	sicien: To the best of my k	nowledge, dea	th occurred at the ti	me, date and	d place, and	due to the c	ause(s) an	d manner as	stated.
	Me Ho	Medical Certification:	(Check only 2 Medical Exem	iner: On the basis of exami and manner stated.	nation and/or ii	nvestigation, in my o	opinion, death	th occurred	at the time, d	ate and pl	ace, and due	to the cause(s)
	To the Hospital or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	M	29b. Signature and title of certifier	NI 1		29c. Licens	se number		2	9d. Date s	signed (Month	, Day, Year)
			1) other Ar	11/2/ (M).		AF al	6421	M-43	64 3	Juli	19.	2005
	0,		30. Name and address of person who o	completed cause of death (II	tem 23a) (Tvne		Ψ (Δ (JU 113		-	٠	
	13		Natalya N-tank, mi		e stern		Tiha	a Hen	land Ba	4 Used	Media	al Center
	St	ate	31. Date filed (Month, Day, Year)	32. egistrar's Sig	mature	boote				3 7	-	al Centry
	×		1111 157	1117 1 180 at 12 0	AT A	1						

			1 - For State Registrar	State of Maryl	•	artment of H			001	15 2	2271
		¥	1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month		3.	Time of Death
	Physici /Medic		Donald Frankli	n Waltemeye	er			July 11,		Year Q	:00 P M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of		
			7274 Conley Stre	et		Balt	imore				
	Funeral		5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace ((State or Foreign
	Director		213-46-3756	XM 2□F 58	Yrs.	livioning Buyo	Tiodis Will.	July 23,	1946	Maryl	
	p		Usual Residence of Decedent 10a. State 10b. County	100	: City, Town or Lo	agation				404.1-	ald On Nicola
	shon	-	Tod. State	100							side City Limits ☑ Yes 2 □ No
	Ba-f	ecto	Maryland		Baltim						20103 2010
	vith to	5	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	nat Country?	
	s 23g	Funeral Director	7274 Conley Stre			2122			US.		
	er de Itam Der r	nu	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	was Decedent of F If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto F	Rican, etc.)		- American Inc White, etc.	dian,
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:		1⊡Yes 2⊠No	Specify:		Specify:	TeTh i	-
21215-0036	72 hours after death with the Maryland natural', or Itams 23e or 28e-f show deat Examinat must be rediffed at	edi	15. Decedent's Ed		16a. Dece	dent's Usual Occup	pation	10	6b. Kind of Busi	Whi.	
15	n n	plet	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retired	during most of workin d)	g		,	
212	filed within Hygiene. that than than int, It a Mac	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Detec	ctive Ser	geant		County (Govern	ment.
	illed Hygi othar ant, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name				
a	ould be Mental Mrkad o	To B	Ellison Webste	r Waltemeye	er		Pearl V	7ictoria	Stable	ey	
Maryland	S L	_	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street	and Number or Rural	Route Number,	City or Town, St	tate, Zip Code	9)
	pernit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra <u>onc.</u>		Kathy A. O'Hallor	an / Fiance	7274	l Conley	St., Balti	more, M	D 21224		
Baltimore,	s 1 a of He item		20a. Method of Disposition		b. Place of Dispo	sition (Name of natory or other place	ce) Da	ate 2	0c. Location - C	ity or Town, S	tate
E	Page ent c nt: # ry or		1 □ Burial 2 □ Cremation 3 □ '4 □ Donation 5 ☑ Other (Specify	Removal from State	-		Cem. 7-15	5-05	Baltimo:	re. Mai	rvland
=	nit.		21. Signatur of vine A Service Li	,			ss of Facility uneral Hon				1
ä	Dep Imp any		MAN an	e #	I.	317 Coke	uneral Hon sbury Road	ne, P.A. L. Abingo	don Ma	ryland	21009
8760,	Physician /Medical Examiner pe practical and price price programmer programme	Ical Examiner	23# Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor	nsequence of):	ANC	ng, such as cardiac or	respiratory arres	st,	Inter	roximate val Between et and Death
P.O. Box 6	requires that the death certificate be execut een signed by the attending physician and nould be detached for use as the burial-tran	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of	23c. If yes, outcome of principle in the program of the program of the program on tributing to death but not	Fetal death 3 Cof death 5 C	Ectopic pregnancy Other (specify)		23e. Did toba	23d. Date Month	h Day	Year use of death?
rd	w require been sig should b	ed						1 X Yes	2 □ No 3	Probably	4 Unknown
ecords,	> 0 70	Completed						24a. Was an	24b. We	ere autopsy fir	ndings available
α	9 1	E O						autopsy	ed ₂ 2 dea	or to complete ath?]Yes 2 1 1	on of cause of
Vital	ician: The certificate ector, pag	ø	25. Was case referred to medical				26. Place of Death		-	J 1 65 2 1	40
>		0.0	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Oth			ce 6 □Other	(Specify)	
ion of	Jing After fune	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		f 28c. Injur Wor		8d. Discribe how			
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str oecify)	reet, factory, office	2	8f. Location (Stre City or Town,	eet and Number State)	or Rural Rout	te Number,
	To tha Hospital or within 24 hours afte To tha Funeral Dir completely filled in	edical	29a. Certifier (Check only one) (Check only one)	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, death mination and/or in	h occurred at the tir vestigation, in my o	me, date and place, a ppinion, death occurre	nd due to the cau d at the time, dat	use(s) and mann e and place, an	ner as stated. d due to the c	cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1 110		29c. Licens			d. Date signed (,
	d		Cule	re mo		DI	6354		TULY.	13,20	005
1/2	111		30. Name and address of person who EW COLE S7	-AGNES	(Item 23a) (Type,	Print)	6354 AVE BI	ALTIMO	RE M	DZ	1229
	Sta Regist		31. Date filed (Month, Day, Year) 5	32. Refistrar's S	Signature	houtes					

	•	1 - For State Registrar	State of Maryland	•	tificate of L		nentai H	ygien Reg. N	200	15	23272
D		Decedent's Name (First, Middle, Last	t)				2. Date of D	Death	ay	Year	3. Time of Death
Physici /Medic		JAMES	ROBERT	ALLEN	1		JULY	14	2005		3:30P.M
Examin	ner	4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4	c. County		
		5936 JOHNNYCAKE R		nd frieddaydayd	If Under 1 Year	of Under 24 Hrs.	re	lies la		CC 1+	imore
uneral irector		5. Social Security Number 6. Se	XM 2□ F 94	Yrs.	Months Days	Hours Min.	8. Date of E Month, I	Day, Yea	911	Cou	place (Stete or Forei ntry) MD
ii ectoi		213-09-4274 Usual Residence of Decedent		1							
how		10a. State 10b. County		Town or Lo	cation						10d. Inside City Limi 1 ☐ Yes 2
Ba-f s	Director	MD Bal	to.	291	timore	2					
or 2	Dire	10e. Street and Number 5936 JOHNNYCAKE R	ΩΔΏ		10f. Zip Code 21207			_	Citizen of V JSA	Vhat Cou	ntry?
n or results and wenter rygener. If item 27 is marked other than "naturel; or items 23a or 28a-f show If item 27 is marked other than "naturel; or items 23a or 28a-f show or other treumatic event, the Medical Examination use the invitibod at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13 \	Vas Decedent of His	enanic Drigin? (Sr	ecify Ves or I	1		a - Ameri	can Indian,
r Item	Fun	1 Never Married 2 Married	Amed Forces?		f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	•••	Blac	k, White,	etc.
el', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 'A' Year or Dates:	1	1□Yes 2∏ No	Specify:			Specify	BLA	CK
natur	Completed	15. Decedent's Edi (Specify only highest grad		16a. Deced	lent's Usual Occupa kind of work done d	tion	rina	16b.	Kind of Bu	siness/lr	dustry
Meg	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired)		9		amii a		
her th		12 17. Father's Name (First, Middle, Last)		SUFE	ERVISOR	18. Mother's Nam	o (First Mida		ETH S'		
ed of	Be										
and Mental Hyglene. Is marked other than eumatic event, the Ms	2	WILLIAM ALLEN 19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	ng Address (Street a		IRGINI				p Cade)
27 Is r treu		MARY B. ALLEN/WIF			6 JOHNNY						
Item 2		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of natory or other place	!	Date		Location -		own, State
nt: If ry or		1 □XBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Hemoval from State		LE VET CH	1	2005 -	CRC)WNSV	ILLE.	, MD
Department of Healt Importent: If Item 2 any injury or other once.		21. Signature of Funeral Service Licens			. Name and Addres	and the second second					
Impol any ir		James of 7	whoten	1	701 LAURI	ENS STREE	T, BAL	то.,	MD 2	2121	7
		23a. Part1. Enter the disease, or comp	olications that caused the death.	Do not ente	er the mode of dying	, such as cardiac	or respiratory	arrest,			Approximate Interval Between
ysician	70. 1	Immediate Cause (Final disease or condition	a EXTREME (OLA	AGE C	au					Onset and Death
ledical		resulting in death)	Due to (or as a conseque	ence of):	700	y					
aminer	L.	Sequentially list conditions,	b. Dementi	O ₁						_	3 yrs
sit	line	if any, leading to immediate	Due to (or as a conseque	ance or):						4	
sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):							
physician the buria	dicai E		d								
	a a										
use	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand		Testania arangana.				23d. Dat	e of deliv	егу
atte	sicia	in the past 12 months?	4☐ Pregnant at time of dea		Ectopic pregnancy Other (specify)			-	Mo	nth	Day Year
0 0	hys	9 🗆 Unknown					112				
by the	0	Part II. Other significant conditions of	ontributing to death but not result	ding in the u				d tobacc	.		the cause of death? bably 4 Munkno
igned by be detac	b			itilig ili tale u	nderlying cause give	n in Part I.	1	7	0 TX 1-		Dably 4 DORKIN
De pe	b			ming in the d	nderlying cause give	on in Part I.	1	Yes	2 200	3 Pro	_
as been sign 2 should be	b				nderlying cause give	in in Part I.	1 [24a. W	as an topsy	24b. \	Were autorior to co	opsy findings availa empletion of cause
ate has been sign page 2 should be				ang in the u	nderlying cause give	n in Part I.	1 [24a. W	as an topsy rformed	24b. \	Were autorior to codeath?	opsy findings availa empletion of cause 2 No
certificate has been sign rector, page 2 should be	Be Completed by	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Dea	1[24a. W au pe 1 □ Yes	as an topsy formed 2 2 2 2 2 2 2	24b. \	Were autorior to codeath?	ompletion of cause 2 ☐ No
his certificate has been signi il director, page 2 should be	To Be Completed by	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{X} \) No		ER/Outpatier	nt 3 DOA	26. Place of Dea	1[24a. Wau pe 1 Yes	as an topsy formed (control of the control of the c	24b. \	Were autorior to codeath?	ompletion of cause 2 ☐ No
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earn. tor: After this certificate has been sign the funeral director, page 2 should be	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At hon	ER/Outpatier 28b. Time of Injury me, farm, str	nt 3 DOA Other	26. Place of Dea on 4 □ Nursing H at	24a. W au pe 1 \sum Pe th (Check onl) ome 5 \sum Re 28d. Describ	as an topsy formed (s 2 d) y one) esidence how in	24b. \\ ? No 6 □Oth ijury occurr	Were autrorior to codeath? I Yes er (Special	ompletion of cause 2 ☐ No
iffer death. Director: Affer this certificate has been sign. in by the funeral director, page 2 should be	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury me, farm, str	nt 3 DOA Other	26. Place of Dea on 4 □ Nursing H at	24a. W au pe 1 \sum Pe th (Check onl) ome 5 \sum Re 28d. Describ	as an topsy formed (s. 254) y one) esidence es how in	24b. \\ ? No 6 □Oth ijury occurr	Were autrorior to codeath? I Yes er (Special	fy)
iffer death. Director: Affer this certificate has been sign. in by the funeral director, page 2 should be	Certification; To Be Completed by	25. Was case referred to medical examiner? 1	28a. Date of Injury 2 28a. Date of Injury 2 28a. Place of Injury - At hon building, etc. (Specify) 28b. Place of Injury - At hon building, etc. (Specify)	ER/Outpatier 28b. Time of Injury me, farm, str	of 3DOA Other Work 1D of 100 o	26. Place of Dea 1	24a. W pu pu pu pu pu pu pu pu pu pu pu pu pu	as an topsy formed so 250 y one) esidence how in (Street Town, St.	24b. V	Were autorior to codeath? I Yes er (Speciared	mpletion of cause 2 No fy) al Route Number,
iffer death. Director: After this certificate has been sign in by the funeral director, page 2 should be	To Be Completed by	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury · At hon building, etc. (Specify) 29 and the basis of examination and manner stated.	ER/Outpatier 28b. Time of Injury me, farm, str) vledge, death on and/or in	of 3 DOA Other Work M 1 To reet, factory, office th occurred at the time vestigation, in my open.	26. Place of Dea T 4 Nursing H at ?? fes 2 No	24a. Way au purchase the (Check online) 5 AR 28d. Describ 28f. Location City or 1 and due to timed at the times.	as an topsy formed (s. 254) y one) asidence be how in a (Street Town, St. and cause e, date a	24b. V	Were autorior to ⇔death? I ☐ Yes er (Speciared er or Run anner as and due	mpletion of cause 2 No fy) al Route Number, stated. to the cause(s)
his certificate has been signi il director, page 2 should be	Certification; To Be Completed by	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury · At hon building, etc. (Specify) 29 and the basis of examination and manner stated.	ER/Outpatier 28b. Time of Injury me, farm, str) vledge, death on and/or in	of 3 DOA Other Work M 1 To reet, factory, office th occurred at the time vestigation, in my open.	26. Place of Dea T 4 Nursing H at ?? fes 2 No	24a. Way au purchase the (Check online) 5 AR 28d. Describ 28f. Location City or 1 and due to timed at the times.	as an topsy formed (s. 254) y one) asidence be how in a (Street Town, St. and cause e, date a	24b. V	Were autorior to ⇔death? I ☐ Yes er (Speciared er or Run anner as and due	mpletion of cause 2 No fy) al Route Number, stated. to the cause(s)
iffer death. Director: Affer this certificate has been sign. in by the funeral director, page 2 should be	Certification; To Be Completed by	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury · At hon building, etc. (Specify) 29 and the basis of examination and manner stated.	ER/Outpatier 28b. Time of Injury me, farm, str) vledge, death on and/or in	of 3 DOA Other Work M 1 To reet, factory, office th occurred at the time vestigation, in my open.	26. Place of Dea T 4 Nursing H at ?? fes 2 No	24a. Way au purchase the (Check online) 5 AR 28d. Describ 28f. Location City or 1 and due to timed at the times.	as an topsy formed (s. 254) y one) asidence be how in a (Street Town, St. and cause e, date a	24b. V	Were autorior to ⇔death? I ☐ Yes er (Speciared er or Run anner as and due	mpletion of cause 2 No fy) al Route Number, stated. to the cause(s)
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JET 05-03296 Kwaku Afrifa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland /	Department of	f Health and Mental Hygi	en
	O .: (1)		

Kwaku		For State Registrar	State of Maryland / D	epartment c Certificate		Mental Hygi	ene • • • • • • • • • • • • • • • • • • •	22272
Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Death	2005 Year	1.05 P M
/Med	ical	Kwaku Afrifa 4a. Facility Name (If not institution, give s	treat and number)	4h City Toy	wn, or Location of Dea	May 12	4c. County of Dea	11.03
Exami	ner	517 Baltic Avenue	noot and numbery				, 6. 664, 6. 262	
Funera		5. Social Security Number 1171 6. Sex	7. Age (In yrs. last birth	Balti nday) If Under 1 Y Months D	'ear If Under 24 Hrs ays Hours Min		9. Bir	thplace (State or Foreign
Director		1 💢		rs.	ays Hours Min	Aug 23,		ountry) unk
and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Aaryli f sho	ō	MD		imore				1 GYes 2 □ No
the 1	rect	10e. Street and Number	ратс	10f. Zip Co	ode	10	og. Citizen of What Co	ountry? unk
h with	ai Di	517 Baltic Avenue	<u> </u>		21225			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pepariment of 1 and 2 should be filed within 7.2 hours after death with the Maryland. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. Its Medical Estantinal must be notified at once.	by Funeral Director	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	If Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify: 1	
ithin 72 ho ne. nen "natur Nedical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed)	Decedent's Usual C Give kind of work of life. DO NOT use r	fone during most of wo	orking unk	16b. Kind of Business	^{/Industry} unk
id be filed w ental Hygier ked other th c event, In	Be Cor	unk un 17. Father's Name (First, Middle, Last)	k	un	k 18. Mother's Na	ıme (First, Middle, M	Maiden Sumame)	unk
2 should and Mer Is marke	To	19a. Informant's Name/Relationship (Typ	1		treet and Number or F			Zip Code)
1 and Health		O.C.M.E. 20a. Method of Disposition			Street Bal		D 21201 20c. Location - City or	Town State
Pages ment of ant: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ri 3 ☐ Other (Specify)	silloval itolli State	Disposition (Name of the crematory or other	r place)		coo. Ecounion Only or	, , , , , , , , , , , , , , , , , , , ,
permit. Pages Department of Important: If It any injury or o		21. So, at use of Funeral Selvice License Ronald S. W	aic, Director	State An	Address of Facility atomy Boar e, MD 212		Baltimore	Street
Pnysiciar /Medica Examiner		23a. Pant . Enter the disease, of compli- shoot, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		otic Ca	dieverseude	1 00000		Approximate Interval Between Onset and Death
ficate be executed physician and is the burial-transit	ai Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
ath certi	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregi			23d. Date of de Month	livery Day Year
law requires that the de as been signed by the a	by	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying caus	se given in Part I.		pacco use contribute to	o the cause of death?
The larate has	Completed					24a. Was ar autops perform 1 X Yes 2	y prior to	utopsy findings available completion of cause of
Physiclan: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		26. Place of De	eath (Check only on		
g Phys er this eral di	tion: To	1 XYes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Ti		Injury at Work?	-	nce 6 Other (Spenier injury occurred	ocify) Scene
To the Hospital or Attending within 24 hours efter death. To the Funeral Director: Afte completely filled in by the fune	Sertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, o	ffice	28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
as Hospit n 24 houn se Funera	edical C	29a. Certifier 1 Certifying Physical Control C	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the following death occurred at the followin	the time, date and place my opinion, death occ	ce, and due to the ca curred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	hall mo		icense number OCME		ed. Date signed (Mon lay 13 2005	
		30. Name and address person who co	mpleted cause of death (Item 23a) (Type, Print)	1 Penn Str	eet Balt	imore, Mar	yland 21201

State Registrar

31. Date filed (Month, Day, Year) JUL 1 8 2005

		,	1 - For State Registrar	State of Marylan		rtment of Hetificate of L			ene NG A A E	00071
i	Physici		1. Decedent's Name (First, Middle, Last) Bertha		Brown			2. Date of Death Month 7 13	Day Year	1:45p M
	/Medic Examin		4a. Facility Name (If not institution, give: Future Care N.H.			4b. City, Town, or Baltin	ore	, 1	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Security Number 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) 2-22-1.	ear) Cou	place (State or Foreign intry) N.C.
	ryland thow		10a. State 10b. County	10c. Cit	y, Town or Lo					10d. Inside City Limits
;	the Ma	ecto	Md. NA		Balt	timore		100	. Citizen of What Cou	1 XYes 2 No
	23a or	al Di	4800 Seton Drive			2121	5		USA	may.
336	urs after dea ai', or Itema	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	l If	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	14. Race - Ameri Black, White Specify:	
21215-0036	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Beginnerian: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, it e Medical Evanitier must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Deced (Give life. L		tion uring most of workin	g	Other Peop	ndustry
ا 2 کا	other	Be Co	3rd grade 17. Father's Name (First, Middle, Last)		L	Domestic	18. Mother's Name			te nome
Maryland	Menta Menta Markad Markad	To E	Nathaniel	Alsto			Emily		Harri	
Mar	nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relationship (Ty Maxine Huddley	npe, Print) Niece		•	Ave., Ba		City or Town, State, Zi	
altimore,	Pages 1 ar ment of Hea ant: If item ury or othe		20a. Method of Disposition 1 Seurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. P	lace of Disposemetery, crem	sition (Name of natory or other place cmel Cem.	Da	ate 20	c. Location - City or T	own, State
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licens	Long	22.	Name and Address March F.	- 1		ore, Md. E. North	21202 Ave.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	ISTVE		such as cardiac or			Approximate Interval Between Onset and Death
68760,	ficate be executed physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq d.						
	The law requires that the death certifics tie has been signed by the attending phoage 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 t No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	rery Day Year
rds, P	w requires that been signed b should be deta	by	Pan II. Other significant conditions con AL 2M & I m & R'S	ntributing to death but not res		iderlying cause give	n in Part I.		cco use contribute to a	the cause of death?
	i: The law ri icate has be r, page 2 sh	Completed						24a. Was an autopsy performed 1 Yes 2 L	prior to co	opsy findings available ompletion of cause of
<u> </u>	ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	- Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	0the	26. Place of Death		ce 6 □Other (Speci	fv)
ion o	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 28	Bd. Describe how		97
Divis	To the Mospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office	25	8f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	Hosp 24 hou Funer stely fill	edicai	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and place, ar inion, death occurre	nd due to the caus d at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier			29c. License		29d	. Date signed (Month,	Day, Year)
	0,	Į,	blus mid			D50	59107	0	7-15-2	w5
2	1		30. Name and address of person who co	ompleted cause of death (Item		*	US RM T	IMORE	Mp 2/2	-15
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's gigna	iture	South	, , , , , ,	TIAJUIT C		' .)

Elaine Bazis 05-04557 RPD

)			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F		, ,	jiene	22275
	(A)	3	Decedent's Name (First, Middle, Last)				2. Date of Dear	th	3. Time of Death
4	Physici /Media		e Elaine Bazis					July 6.	Day Year 2005	1945 P [™]
	Examir	and the same	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	-	4c. County of Deat	
	* * * * * * * * * * * * * * * * * * * *	4	University Hospit			Baltimon				
	Funeral		5. Social Security Number 6. Se 159–32–4675	x 7. Ag ☐M 25√3 F	e (In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs Hours Min		Year) 9. Birti	hplace (State or Foreign untry)
<i>7</i> 4	Director		Usual Residence of Decedent		.64			12-8-19	940	PA
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	9-f	ctor	PA Delawa	re	Norwood					Yes 2 No
	th with the 23a or 28 lat be not	ai Director	10e. Street and Number 208 Trites Ave			10f. Zip Code 1907	4	1	og. Citizen of What Co USA	untry?
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ad other than "natural", or items 23a or 28e-f ehow event, the Madical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	
5-0	72 h	etec	15. Decedent's Edi (Specify onfy highest grad	cation le completed)	(Giv	edent's Usual Occup e kind of work done	during most of wo	orkina	16b. Kind of Business/	Industry
121	C	Completed	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired it Coordin	d)	9	Health	Care
	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)		OH.	ic doordi.		me (First, Middle, i		Care
Maryland	2 should be filled withir and Mental Hygiene. Is marked other than aumatic event, the M	To Be	UNKNOWN					cAllister		
Mar			19a. Informant's Name/Relationship (T) Michael Bazis	rpe, Print) Son					r, City or Town, State, 2	Zip Code)
ē,	is 1 and 2 of Health item 27 other tra		20a. Method of Disposition		20b. Place of Disp			W. 100	20c. Location - City or	Town, State
E	0 0		1 ☐ Burial 2 ☑ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Bayview	Crematory		7-13-05B	Baltimore,	MD
Baltimore,	permit. Peges Department of important: If it any injury or o		21. Signature of Euger S rice Licens K Gregory Fink	MO11		R. Name and Addre		; Glên Bu	ırnie, MD 2	1061
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause ne cause on each li	d the death. Do not er					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Hultin	le ini	ces				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of:					
Ъ	2 Z	<u></u>	Sequentially list conditions,	b. ————————————————————————————————————	a consequence of):					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence or):					
ď.	execunand and all-tra	Exai	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
8760,	cate be executed obysicien and the burial-transit	dical		d					100	
9	tificat ng phy as th	0								
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of del Month	ivery Day Year
	res that igned b be deta	by Pi	Part II. Other significant conditions co	ntributing to death t	out not resulting in the	underlying cause giv	ren in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ğ	w require been sig should b	ed				.		1 🗆 Y	es 2√No 3⊟Pr	obably 4 DUnknown
of Vital Records,	ne law re has bee ge 2 sho	Completed						24a. Was a autops	sy prior to d	topsy findings available completion of cause of
a			or W						med? death?	2 No
ξ	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital:	057 FD/O	ot 30 DOA Ott	ar	eath Check only or	***	
ō	Phy ar this aral d	7: To	27. Manner of Death	1 ☐ Inpati	ury 28b. Time	ant 3L DOA	4 🗆 Nursing	7	ence 6 Other (Specow injury occurred	4 4
jon	nding ath. r: Afte	atio	1 □ Natural 5 □ Pending 2 ■ Accident investigation	7 = (0 =			k? Yes 2. ▼No	posserge	L'in wood	vehicle
Division	or Attending after death. Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At home, farm, s				treet and Number or Ru	iral Route Number,
Ö	s afte el Dir ed in	Certification:	4 - Hornicide	building, e	ic. (Specify)	STATE		Ecstosus	-11-70 war	dem, Mo
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best ner: On the basis of and manner st	of examination and/or i	ith occurred at the til nvestigation, in my o	me, date and place opinion, death occ	e, and due to the c surred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To thi Po thi Somple	Me	29b. Signature and title of cerafter	(7.0	29c. Licens	e number	2	29d. Date signed (Monti	h, Day, Year)
	1		Motion !	· -	600 h.	0.C.N	1.E.	.J·	uly 7, 2005	5
	121		30. Name and address of person who o	ompleted cause of	death (Item 23a) (Type	, Print)				
a.	Sta	210	31. Date filed (Month, Day, Year)	32. Segisti	11 Penn St	reet, Bal	timore,	Maryland	21201	
	Regist		.1111 1 8 20	307	. H. A.	alle				

Keith Aaron Butler, Jr. Unknown 05-04723

05-04723 crn	1	For Stata Registrar		State o	f Maryla		artmen ertificat				lental Hy	giene	~ ~	0.5	232	76
Physician		Decedent's Name (First,									2. Date of De Month	eath Da 1	У	Year	3. Time of	
/Medical Examiner	1	Keith Aaron E 4a. Facility Name (If not ins 79 N. Culv	stitution, give	street and nur	mber)			Town, or 1time	Location o	of Death	July			2005 y of Death N/A	3:55	<u>A</u> ^M
Funeral Director		5. Social Security Number 213–98–4412		X XM 2□ F	7. Age (In yrs	V) If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 08-03-19	rth ay, Year) 981		9. Birthpl Coun Maryla	ace (State o try) nd	or Foreign
ryland		Usual Residence of Deced	County		10c. C	ity, Town or L								10	Od. Inside C	,
Site death with the Marylar ritems 23e or 28s-1 show the rightland at the rightland at Einstein Director	20	MD 10e. Street and Number	NA			Bal	timore	Code				10g. Cit	tizen of	What Coun		2 No
1238 or	2	6112 Fairdel A	Avenue A		14. 2			2120					USA			
ter des	2	11. Marital Status 1 XNever Married 2(3 Widowed 4 Di		12. Was Dece Amned Fo 1 Tyes If Yes, Giv Year or D	2XX No ve	U.S. 13	Was Deced If Yes, spec				in? (Specify Yes or No- Puerto Rican, etc.) 14. Race - American Indi Black, White, etc. Specify: Black					
od within 72 hours ygjene. her then "natural" it, the Madical Ew	חבופר	(Specify only		de completed)		16a. Deci (Giv life.	edent's Usua e kind of wo DO NOT us	al Occupa rk done d se retired	ation during mos	st of work	ng					
d 212; filed within Hygiene. there then out, tree My		Elementary/Secondary (College (1	1-4or 5+)		tudent	dent Schools 18. Mother's Name (First, Middle, Maiden Sumame)								
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or any injury or other traumatic event, tre Modical Eventuals.	מ	17. Father's Name (First, A Keith Aaron Bu							18. Moth		(First, Middle	, Maider	ı Surnar	me)		
Mary de 2 sho lith and 1 st is mu		19a. Informant's Name/Re		ype, Print)							e, MD 21	-			Code)	
Baltimore, permit. Pages 1 an appartment of Heal mportent: if tiem.' my injury or other		20a. Method of Disposition 1 🖾 Burial 2 □ Crem		Removal from	20b. State	Place of Disp cemetery, cre					Date			- City or To	wn, State	
altim mit. Par bartmen bortent: rinjury	i		4 Donation 5 Other (Specify) Mt. Zion Cemetery 07-21-05 Lansdowne, MD 22. Name and Address of Facility													
g ggggg		Im	22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 Approximate Interval Between and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 Approximate Interval Between In													
Service be executed Examiner and supering the burial-transit	ical Ex	shock, or hear failur Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ſ	a. Due to b. Due to	(or as a conse	equence of:	gunshot wounds							Interval Bei		
Box 6 eath certif	ysician/me	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 Yes 2 No 9 Unknown	ant		ointh 2 ☐ Fei nant at time of	tal death 3	□Ectopic pi □ Other (sp							ate of delive	,	Year
IS, P. res that signed by the deta	2	Part II. Other significant of	onditions co	ontributing to d	eath but not re	sulting in the	underlying a	ause give	en in Part	l.			use con	tribute to th		
Il Record The taw require tale has been si	Jered										24a. Was		24b.	Were autor	ably 4 🗍	available
al Rec	E										auto perf 1 □tyYes	ormed?		prior to con death? 1-12 Yes	npletion of d 2□ No	ause of
f Vital I ysiclen: Thysiclen: The secutificate director, page	0	25. Was case referred to examiner? 1	-	Hospital:	Inpatient 2[☐ ER/Outpatio	ent 3 DC	Othi			me 5 ☐ Res		6 XOt	her (Specify	at s	scene
ding Phys h. After this tuneral di		27. Manner of Death 1 Natural 5	Pending	Great	of Injury th, Day Year)	28b. Time Injury	of 2	8c. Injun Worl	y at k?	,	28d. Describe				+	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The taw requires that the dwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached and in the funeral director.	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Place	of Injury - Ating, etc. (Spec	home, farm, s	-	1 [] '	105 219		28f. Location	wa.State		ber or Rura.	-	nber,
Hospita 24 hours Funera	edical			ysician: To the	asis of examin	nowledge, dea	th occurred									s)
To the within To the comple	Me	29b. Signarure and title of certifier Pic O L 29c. License number OCME														
7		30 Name and address of person with completed cause of death (term 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201										21201				
State		31. Date filed (Month, Jan)	IL 8	2005 32. F	Registrar's Sign	nature	1 4			=====				11110		

		•	1 - For State Registrar			d / Depa		Health ar	nd Mental Hy			23277
			1. Decedent's Name (First, Midd	lle, Last)					2. Date of Di	eath Day	Year	3. Time of Death
	Physici /Medi		Stephen	R.	Borow	У			34 LY	14	2003	5 7:45 PM
	Examir		4a. Facility Name (If not institution	on, give street and numb	oer)		4b. City, Town, o		Death	4c. C	ounty of Deat	
			Lorien Nursing	Home			Belai			HI	ARFOR	CS CS
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la		If Under 1 Year Months Days		Hrs. 8 Date of Bi Min. (Month, D	rth ay, Year)	9. Birti Co	hplace (State or Foreign untry)
	Director		216-09-9201 Usual Residence of Decedent	TALL CO.	84	Yrs.			Min. (Month, D) October	2, 1920)	MD.
	and #		10a. Stale 10b. Count	у	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	the Marylar 28a-f show notified at	ō	MD	N/A		Balt	imore					1 DXYes 2 □ No
	28a	rec	10e. Streel and Number				10f. Zip Code			10a. Citize	en of What Co	untry?
	3e or	i i	6704 Danville	Avenue			2122	2		US		,
	within 72 hours after death with the Maryland one. than "natural", or items 23e or 28e-f show than matter must be notified at the Madical Examinar must be notified at the Madical Examinar must be notified at the Madical Examinar must be notified at the Madical Examinar must be notified at	by Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S	5. 13.			n? (Specify Yes or N Puerto Rican, etc.)		I. Race - Ame	
9	after or Ite	Ē	1 Never Married 2 Ma	rried Armed Force	□No		ir Yes, specify Cub 1 □ Yes 2 🛣 No		Puerto Hican, etc.)		Black, White	
21215-0036	ral,	1 by	3 X Widowed 4 □ Divorce	d If Yes, Give Year or Date	es:		THES ZONO	Specify:		S	Specify: W	hite
5-0	72 hours "natural",	Completed	15. Decede (Specify only high)	nt's Education est grade completed)		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most o	of working	16b. Kind	of Business/	Industry
21	within ene.	ם	Elementary/Secondary (0-12)	College (1-4	lor 5+)			ed)	· ·			
	Hygie thert	ပိ	8 years 17. Father's Name (First, Middle	/ actl		Bri	cklayer	10 Mathada	s Name (First, Middle		tructi	on
anc	Mental Hygiene Reked other than atic event, the		Walter Borowy					1	slawa Swis		umame)	
Ž	should by Menta marked marked	유	19a. Informant's Name/Relation			10h Maili	a Addanga /Cina		or Rural Route Numb		T	T. O. (1)
Maryland	d 2 sho th and th and traum	T	Mark Borowy	Son	1				, Fallstor			
	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygene. Importent: If tien 27 is marked other than "natum any nijury or other traumatic event. It medical ONCE. 30 pt 0.1 v.		20a. Method of Disposition				osition (Name of matory or other pla	1 -	Date		ation - City or	
2	ages int of t: If it	4	1 Deurial 2 Cremation				matory or other pla aus Cemete	0 (uly 18,			
Baltimore,	permit. Pag Department Importent: any injury c		* 4 □ Donation 5 □ Other (30.				2005		imore,	
Ba	Departr Imports any inj		In thou		o OVII		onnelly	Funera.	l Home Of int Road,	Dunda	lk, P.	A 51222
	ESWE?		23a. P. 1. Enter the disease, shock, or heart failure.	or complications that cau	ised the death				ardiac or respiratory a		LIC, Ma.	Approximate
	Dhusisian		shock, or heart failure. Us Immediale Cause (Final	st only one cause on eac	sh line.		T. 1		- 1		11	Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a Do 6	as a consequ	1000 or	schen	nic s	ardiom	YOPA	lly	years
E	Examiner				as a consequ	The oil.			/	1		/
		ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	r de a consequ	ianea of):						
	ite be executed lysician and ne burial-transit	cai Examiner	Cause (Disease or injury that initiated events	S c								
o,	ite be execu iysician and ne burial-trai	EX	resulting in death) Last	Due to (or	r as a consequ	ence of):						
3760,				d								
89	death certifica e attending ph id for use as th	by Physician/Med	IF FEMALE:									
Вох	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal	death 3	Ectopic pregnanc	;y		23	d. Date of deli Month	very Day Year
	0 0	sici	1 Yes 2 No	4☐Pregnar 9☐Unknow	nt at time of de vn	ath 5	Other (specify)				MOHIII	Day real
P.0	requires that the death cer een signed by the attendin hould be detached for use	Phy	Part II. Other significant condit	ione contribution to don	th but not room	leina ia aba		usa ia Bast I	220 Did	***********		the course of death?
S,	es be			Xti	T .	11 -1	inderlying cause gr	Veri ili Fatti,		Yes 2 B		the cause of death?
oro	w requir been s should	etec	- CHADAIL C	- 14186	T-C101	4441	10~					obably 4 Donklown
Records,	as s	Completed				_			— 24a. Was	DSV	prior to c	topsy findings available completion of cause of
A F	: The cate ha	Co							pen 1 □ Yes	ormed? 2☐Mo	death?	2 10 No
Vital	ding Physiclen: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medic examiner?	Hospital:			0.5		f Death (Check only	one)		
of	Phys this al dir	2	1 ☐ Yes 2 ☐ ₩6	1 Linb	patient 2 E		1 3 DOA		ing Home 5 Res			cify)
n	After	ion	1 ☑Natural 5 ☐ Pend		Day Year)	28b. Time o Injury	Wo	ork?]Yes 2∐No	28d. Describe	now injury	occurred	
Division	I or Attending after death. Director: After I in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could		f Injuny - At hor	ma farm et	reet, factory, office			(Street and	Number or Ru	ıral Route Number.
<u>></u>	or A after Direction by	ertif	4 Homicide deter	mined 286. Place o	, etc. (Specify)	eet, lactory, onlos			wn, State)	740771001 01 110	nar Houte Number,
_	Hospitel 24 hours a Funeret I		29a, Certifier TO Certify	ing Physician: To the b	est of my know	viedne deat	h occurred at the ti	ime date and	place, and due to the	cause(s) a	nd manner as	stated
	a Hos 24 h Fur etely	edical	(Check only 2 Medical one)	I Examiner: On the bas and manne	is of examinat	ion and/or in	vestigation, in my	opinion, death	occurred at the time	, date and p	lace, and due	to the cause(s)
	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifi		10		29c. Licen	se number		29d. Date	signed (Month	n, Day, Year)
	- X-		· Ma	1000			Di	910	3	Tal.		770-
n	6		30. Name and address of perso	n who completed cause	of wath (Item	23a) (Type.	Print)	178		INI	14	1005
2	2		Manuel V	1. Lazat	The M	D	Print) & L	aw 5	treet)	Speld	leen,	Mangare
	St	ate	31. Date filed (Month, Day, Yea	r) 32. B	gistrar's Signat	ure	1					21001
	Regist	rar	11.11 1	8 2005		K A	oske)					

	State of Maryland / Department of Health and Mental Hygiene											
	1- State Registragmend item #19b perfit g845 7/19/05 Agertificate of Death Reg. No. 2005 23278											
	1. Decedent's Name (First, Middle, Las	st)	0	•	2. Date of Death	Day Year	3. Time of Death					
an cal	Thomas	James	Bru	01	July	09 2005	3:17 P ^M					
ier	4a. Facility Name (If not institution, give	·		4b. City, Town, or Location of		4c. County of Death						
	Carroll Hospital		71 - 1 - A 1 - A 1 - A	Westminste		Carro						
		M 2□F	(In yrs. last birthday)	Months Days Hours	Min. 8. Date of Birth (Month, Day, Ye	ear) 9. Birth	place (State or Foreign					
	Usual Residence of Decedent		<i>>7</i>		Dec	1950	10 9					
	10a. State 10b. County a	14	10c. City, Town or Lo	cation			10d. Inside City Limits					
ctor	MD		6	altimory	2		1 ☐ Yes 2 ☐ No					
Director	10e. Street and Number			10f. Zip Code	10g.	Citizen of What Cou	intry?					
rai	2923 Sylva	in Hue		alak	+	USI	1					
Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of Hispanic Ori f Yes, specify Cuban, Mexican	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Amer Black, White						
by F	1 ☐ Never Married 2 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 1 No		1 ☐ Yes 2 No Specify:		Specify:	shito					
ed t	15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occupation	161	b. Kind of Business/Ir	ndustry					
Completed	(Specify only highest gra	ide completed)	(Give	kind of work done during mos DO NOT use retired)	t of working							
E O	Elementary/Secondary (0-12)	College (1-4or 5+	Bik	se Manuf	artirer	BilK	e					
BeC	17. Father's Name (First, Middle, Last)	, ,	Pis.	18. Mothe	er's Name (First, Middle, Mai	den Sumame)						
To	Luigino HI	Fredo B	KUMI	(4	elestina	KID	35					
	19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ng Address (Street and Number	er or Rural Route Number, C	ity or Town, State, Zi	p Code)					
	Therese Spo	idaro lu	IFC 2923	SYLVAN AVE. BATA								
	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Dispo cemetery, crei	natory or other place)	Date 200	c. Location - City or T	own, State					
	4 □ Donation 5 □ Other (Specify	-	Metro	Crematory!	7-21-05	50/10 1 V	MID					
	21. Signatura Fundral Service Liden	1596 7/	/ 11	2. Name and Address / Facili	. 1 11 .	T . 0 . 7	N 10.171					
	23a. Part Forer the disease, or com	unlications that caused t	he death. Do not en	TAIN 1939 W	1.0	sessur) +	Approximate					
	shock or heart failure. List only	one cause on each line).	er the mode of dying, such as	cardiac of respiratory arrest,	•	Interval Between Onset and Death					
	disease or condition resulting in death)	a. Mus	Mrs -	Murus								
		Due to (or as a	consequence of):									
e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):									
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.										
EX	resulting in death) Last	Due to (or as a	consequence of):									
dicai	•	d										
Med	IF FEMALE:											
an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	! ☐ Fetal death 3 [Ectopic pregnancy		23d. Date of delive	rery Day Year					
sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	ime of death 5	Other (specify)								
Completed by Physician/Me	Part II. Other significant conditions of	contributing to death but	not resulting in the u	nderlying cause given in Part I	23e. Did tobac	co use contribute to	the cause of death?					
d b			-		1 ☐ Yes	2 □ No 3□Pro	bably 4 Unknown					
ete					24a. Was an	24h Were aut	opsy findings available					
E P					autopsy performed	d? prior to o	ompletion of cause of					
CO	25. Was case referred to medical			26 Place	1 res 2 res of Death (Check only one)	No Yes	2 No					
To B	examiner? 1√2 Yes 2 No	Hospital: 1 Inpatien	t 2 ER/Outpatie	Other	ursing Home 5 Residenc	e 6 □Other (Spec	(fv)					
	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o		28d. Describe how		/					
atlo	2 Accident investigation	7-9-0	T 1404	M 1 ☐ Yes 2 ☐	No BICLYST	collions h	ist ron					
III	3 Suicide 6 Could not be determined		ry - At home, farm, st (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,					
Cel			muny				phesthington					
Medicai Certification:	(Check only 2 Medical Exam	miner: On the basis of 6	examination and/or in	h occurred at the time, date ar vestigation, in my opinion, dea	nd place, and due to the caus ath occurred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)					
Med	one) 29b. Sighature and title of certifier	and manner state	QU.	29c. License number	29d	. Date signed (Month	, Day, Year)					
	Mouse	n (Sh. 1	00 (1.120	OCME	1							
	30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	D		ly 10, 200						
	MANA NASS	A-IRDREU	(non zoa) (1 ype,	111 Penn St	reet Baltimo	ore, Maryl	and 21201					

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

RODEU

egistrar's Signature

LEVINDALE HEBREW HOME BALTIMORE 6. Sex 1 M M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 220-20-7527 90 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 28a-f ehow is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene.

Item 27 is marked other than "natural", or Iteme 23a or 28a-1 ehow other traumatic event, The Medical Explicit in must be notified at BALTIMORE BALTIMORE Directo 10e. Street and Number 10f. Zip Code - ROAD 21209 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Rice 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) ANALYTICAL RESEARCH NATHAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (F Be SAMUEL BEITSCH LEAH 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural R Pages 1 and 2 ment of Health a 2311 FARRINGTON ROAD STANLEY BEITSCH / SON 20b. Place of Disposition (Name of 20a. Method of Disposition LUBAWITZ MUSACH PARI ö 1 TBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If eny Injury or once. * 4 □ Donation _ 5 □ Other (Specify) 07/14/2 21. Signatur aral Service Licensee 22. Name and Address of Facility SOL 8900 REISTERSTOWN RO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition RESPIRATORL **Physician** resulting in death)

Н	JULY	13	ay 3 20	Year 005	7:10 P ^M
n, or Location of Death		4	c. County	of Death	
IMORE					N/A
ar If Under 24 Hrs.	8. Date of Bir (Month, Da	th You	el	9. Birth	place (State or Foreign
ys Hours Min.	06/11/1	1915	5	Cou	NY
					10d. Inside City Limits
					1 ☐ Yes 2 🕅 No
le		10g. C	itizen of	What Cou	intry?
09			1	1 C A	
of Hispanic Origin? (Sp	ecify Yes or No)-		S.A.	can Indian,
Suban, Mexican, Puerto	Rican, etc.)			ck, White	
No Specify:			Specif	y: WI	HITE
cupation		105	Kind of D	lucio c == #	aducto.
cupation one during most of work tired)	ing	160.	VILIO OI B	lusiness/Ir	ioustry
RESEARCH			LEMI	CTDV	
18. Mother's Nam	o (First said-11-			STRY	
	e (FIISI, MIUDIO	, maide	ni oumai	iie)	LEDNES
LEAH					LERNER
eet and Number or Rur	al Route Numb	er, City	or Town	, State, Zi	p Code)
NGTON ROAD	- BALTI	MOF	RE, M	D 21	209
	Date	20c.	Location	- City or T	own, State
ARI 07/1/	/2005	DOG	EDAL	с м	n
	L LEVIN				
					MD 21208
			COAT	LLE,	TI 41 / 15
dying, such as cardiac	or respiratory a	irrest,			Approximate Interval Between Onset and Death
RE					1 Moutit
					LLMAIL
IA					3 MONTH
ENTLA					3 YEARS
					Jerries
				+	
					-
ancy				ate of delive	rery Day Year
<i>'</i>)		į	1411	o-101	- a, 10ai
given in Part 1.	23e. Did	tobacc	use con	tribute to	the cause of death?
	10	Yes	2 No	3 ☐ Pro	bably 4 🗆 Unknown
	24a. Was	an	245	Ware aut	opsy findings available
	auto			prior to co	ompletion of cause of
	1 Yes	2 2	No	1 Yes	2 No
26. Place of Dear	h (Check only	one)			
Other: 4 Nursing Ho	ome 5 Res	dence	6 □Ot	her (Speci	(fy)
Injury at	28d. Describe	how in	jury occu	rred	

Reg. No.

2. Date of Death

/Medical Examiner

physicien and s the burial-transit

as the

BSU

jo

detached

been signed I should be det

page 2 s ector,

in by the funeral dir

After

death.

after death

within 24 hours after To the Funerel DI

Examine

Completed by Physician/Medical

Be

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Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

For State Registra

NATHAN

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

4a. Fecility Name (If not institution, give street and number)

IF FEMALE

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death

4 Pregnant at time of death 9 Unknown

Due to (or as a consequence of).

Due to (or as a consequence of):

Due to (or as a consequence of):

MULTI INFARET

HISPIRATION

3 Ectopic pregnancy 5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 10e, 19b per fh :845 7-18-05 vt. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

BEITSCH

NEMONIA

DEMENTIA

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death Natural 2 Accident

5 Pending investigation 6 Could not be determined 3 Suicide 4 Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 Yes 2 No

Juith AVE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifie

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier MD 29c. License number D25039 29d. Date signed (Month, Day, Year)

7.13,2005

BAST MD 21709

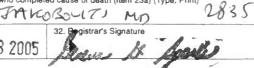
State

31. Date filed (Month, Day, Year)

JULIAN

JUL 1 8 2005

30. Name and a ldr ss of per or who completed cause of death (Item 23a) (Type, Print)



Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed

Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F			ene 	2328	3.0
	Physici	an	1. Decedent's Name (First, Middle,					2. Date of Death Month	Day Year	3. Time of D	
	/Medic	al	Luelle Avis E			4h City Town o	r Location of Death	July 15	4c. County of Deat	7:00	АМ
	Examin	ier	900 Ashton Road	ive sireer and number)		Asht			Montgome		
	Funeral Director		502-03-9081	Sex 7. Age	(In yrs. last birthday, 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Sept. 6,	9. Birtl	hplace (State or	Foreign
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City	y Limits
	Many I sho	tor	Maryland Montgo	merv	Ashton					1 ☐ Yes	2 ∑ No
	ith the or 28;	Olrec	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	untry?	
	ath w	rail	900 Ashton Road			20861			nited Stat		
36	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural; or items 23s or 28s-1 show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 💆 N If Yes, Give Year or Dates:	o 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	e, etc.	
9-0	72 hou	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occup	ation	16	Whi Sb. Kind of Business/		
218	within 7 ene. than "r	Completed	(Specify only highest s Elementary/Secondary (0-12)	College (1-4or 5-	()		during most of working)	ng			
121	filed w Hygier other th		17. Father's Name (First, Middle, La	3	Home	emaker	18. Mother's Name	(First Middle Ma	Own Home		
Maryland 21215-0036	should be f nd Mental h marked of imatic eve	o Be	Vernon Doty Lang					Halverson			
ary	s 1 and 2 should f Health and Men item 27 is marke other traumatic	_	19a. Informant's Name/Relationship		19b. Maili	ing Address (Street			City or Town, State, 2	(ip Code)	
	1 and 2 Health (sem 27 is		William C. Birel	y/Husband			oad, Ashto				
Baltimore,	Pages 1 au nent of Hea int: if item iry or othe		20a. Method of Disposition 1 Main Burial 2 ☐ Cremation 3			osition (Name of matory or other place	1	19,	c. Location - City or		
Itim	그 문란를 .		* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lift		Blueridg	e Cemeter	y 2005	ert A. Pi	hurmont, M	Maryland neral H	l ome/
Ba	permi Depa impo any i		30:05		M00803 B	ethesda-C ethesda,	hevy Chase Maryland	e, Inc. 20814-3	umphrey Fu 7557 Wisco 501	nsin Av	enue
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused	the death. Do not en					Approximate Interval Betw	/een
	Physician		Immediate Cause (Final disease or condition		tatic Col	on Cancer				Onset and De	eath
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):						
	cate be executed oblysician and the burial-transit	Examine	Cause (Disease or injury that initiated events	С							
, 0	e exe sian a	I Ex	resulting in death) Last	Due to (or as a	consequence of):						
8760,	physic physic s the b	dical		d							
.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of 1∐Live birth 24 □ Pregnant at 19 □ Unknown	2 ☐ Fetal death 3 (⊒Ectopic pregnancy ⊒ Other (specify)	,		23d. Date of deli Month	,	ear
Q	s that t ned by a detac	by Ph	Part II. Other significant condition	contributing to death bu	t not resulting in the t	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of de	ath?
ords	w requires been sign should be							1 🗌 Yes	2 X No 3□Pro	obably 4 □Ur	nknown
Vital Records,	The ate h page	Completed						24a. Was an autopsy performe	prior to o death?	topsy findings ar completion of car 2 \(\square\) No	vailable use of
Vita	Physician: This certificated director, p	Be	25. Was case referred to medical examiner?	Hospital		Otto	26. Place of Death	(Check only one)			
of	Phys r this rat dir		1 ☐ Yes 2 💢 No 27. Manner of Death	Hospital: 1 Inpatier	nt 2 ER/Outpatie	- American	4 Nursing non	ne 5X Residen	ce 6 Other (Spec	eify)	-
	Attending r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigat	(Month, Day	Year) Injury	Wor	k? Yes 2 □No		,,		
Division	ial or Attendi s after death. al Director: A ad in by the fu	Certification;	3 Suicide 6 Could no 4 Homicide determine		ry - At home, farm, st . (Specify)	reet, factory, office	2	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Numb	er,
	ital or urs afte ral Dir										
	To the Hospital or within 24 hours after To the Funeral Direcompletely filled in b	edical	29a. Certifier 1 ☐ Certifying (Check only one) Check only one)	Physician: To the best o aminer: On the basis of and manner stat	examination and/or in	th occurred at the tir envestigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau ad at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)	
	To the To the comp	N	29b. Signature and title of certifier	11		29c. Licens	e number	290	d. Date signed (Month	, Day, Year)	
•	0			-W	3	D332	93	Jı	ıly 15, 20	05	
ř	う		30. Name a oddress person wt	Smith. M.D.			venue #13	300 Char	yy Chase,	MD 208	15
	Sta	ate	31. Date filed (Month, Day Year)	32. Reg kra	r's Signature	_	TILLES WIL	out, one	y onase,	200	± J
	Regist	rar	JUL I	2 COA	we &	Goode					

)4 <i>i</i>	721		1 - For Amend Item 1	State of Marylan 9b per fh G84	nd / Depa 7 9-6-6 Cei	artmen)5. ta: rtificat	t of H	ealth and Death	Mental Hy	giene	N N S	23281	
200	Physici	an	1. Decedent's Name (First, Middle, Las	•					2. Date of D		Year	3. Time of Death	
	Physici /Medi		PAMELA BROW						July	12	12 2005 11:		
	Examir	ner	4a. Facility Name (If not institution, give	,				Location of Deat	h	4c. Co	ounty of Death		
			St. Agnes Hospit 5. Social Security Number 6. So		last hirthday)	If Under	altin	NOTE If Under 24 Hrs	8. Date of Bi	rth	N/A		
, K.	Funeral Director			□ M 2 XF 35	Yrs.	Months		Hours Min.	(Month, D	4/196		place (State or Foreign ntry) RYLAND	
	ylanc how		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					1	Od. Inside City Limits	
	ith the Marylan or 28a-f ehow e notified at	ctor	MD N/A		BAI	LTIM	ORE	CITY				Yes 2 □ No	
	death with the Maryland ime 23a or 28a-f ehow I must be notified at	al Director	10e. Street and Number 3310 EDMONDS	ON AVENUE		10f. Zip	212	29			n of What Cour USA	ntry?	
5-0036	urs after al', or Ita Evamina	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2☐ No If Yes, GiveX Year or Dates:	I	Was Deced If Yes, spec 1 Yes		spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)		Race - Americ Black, White, Decify: BLA	etc.	
215-0	"natu	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Deced (Give life. L		rk done d	luring most of wo	rking	16b. Kind	of Business/In	dustry	
2121	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	Con	12TH	2 YEARS	1	NURS	ING				MEDICA	AL	
nd	tal Hid oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	, Maiden Su	mame)		
ryla	d Men narke	To	HARVEY COLE	Control Control	401 14 11		(0)	ROSE	HOUCI				
, Maryland			19a. Informant's Name/Relationship (7 GERALD E. BROW		19b. Mailin	Bra G-GRA	intle NTL	nd Number or Re Y EY AVE	ural Route Numb	er, City or To IMORE	own, State, Zip MD 2	21216	
Baltimore	0 0		20a. Method of Disposition	· -	Place of Dispo- cemetery, cren	natory or o	ther place		Date	20c. Locat	tion - City or To	own, State	
Ë	Pag tment tant: jury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		.)			CEM 7/				WN, MD	
Bal	permit. Pag Department Important: I eny Injury o		21. Signature Jun ral Service Licen	See Sin Stu	Z 22	1. Name an	d Addres LIB	s of Facility H(ERTY H)	OWELL I EIGHTS	FUNER. AVE,	AL HOM BALTI	ME 21207 MORE, MD	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or come short, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. Occlusive Due to (or as a conseq	Pulv	vlona	vy	Mronil	20 emba			Approximate Interval Between Onset and Death	
8760,	rate be executed shysicien and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d.		s I	nr.	om bos	Se <u>S</u>				
O. Box 6	attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 X Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pr				23d	Date of delive	ry Day Year	
ds, P.	n requires thet the de been signed by the should be detached		Part II. Other significant conditions co	ontributing to death but not res	ulting in the ur	nderlying c	ause give	n in Part I.		obacco use		e cause of death?	
Division of Vital Records,	e lav has	Completed by								an 2 psy prmed? 2 \(\sum \) No	deaun ∕	osy findings available inpletion of cause of	
ital	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Place of De	ath (Check only		A		
_	Physiclan: this certific ral director,	To	examiner? 1 √ 2 Yes 2 □ No	Hospital: 1 X Inpatient 2 □	ER/Outpatien	it 3□ DC	Othe	or: 4 🗆 Nursing H	lome 5 ☐ Res	idence 6 🗆	Other (Specify	1)	
ion o	nding Ph ath. r: After th e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28c. Injury at Work? M 1 Yes 2 No									
Divis	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the control of	ome, farm, str	eet, factory	, office		28f. Location (City or To	Street and N wn, State)	lumber or Rura	l Route Number,	
	Hospit 24 hour Funere	edical (ysician: To the best of my kno liner: On the basis of examina and manner stated.									
*	To th within To the	Me	29b. Signature and title of certifier	Hallavn	rd	290	OC]				igned (Month. 14, 20		
	3		30. Name and address of person who o	completed cause of death (Iter	n 23a) (Type,	Print) 11	1 Per	nn Stree	et Balt	imore,	Maryla	and 21201	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Agistrar's Signa	ature A	antes	,						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:20 AM AUTHERN JUI 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL TIMORP ENTEL Social Security Number If Under 24 Hrs. Hours Min. Birthplace (State or Foreign
 Sountry) 6 Sex 7 Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days 1 M 2 F Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Tes 2 No Director 10f. Zip Code 10g. Citizen of What Country? ō items 23a by Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 5 Specify: Specify: W/ 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Cotlege (1-4or 5+) Elementary/Secondary (0-12) is marked other than f Health and Mental Hygiene. BACKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Be ပ 19a. Informant's Name/Relationship (Type, Print) I Route Nur n, State, Zip Code) 19b. Mailing Address (Street and Number or Ru other City or Town, State 20a. Method of Disposition 20b. Place of Disposition 20c. Location permit. Pages to Department of Himportant: If ite any injury or ot 1 Burial 2 □ Cremation 3 Removal from State ¹ 4 □ Donation / 5 □ Other (Specify) 21. Signature of Juneral Sprvice Licens ENTIM! er he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Immediate duse (Final disease or condition Physician MYOCARDIAL resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): P.O. Box 68760. the attending physician Completed by Physician/Medical IF FEMALE esn. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy õ Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 Unknown 1 Yes 2 No peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 2 No 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this filled in by the funeral 27. Manner of Death 28c. Injury at Work? Date of Injury 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, larm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number KES MD 001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21224 MEDICAL EASTERN AVE. BALTIMORE, MD ENTER BAYVIEW 4940 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 0 15 1. Decedent's Name (First, Middle, Last) Dete of Deeth
 Month **Physician** Margaret Ann (4 Fecility Name (If not institution, give street end number) 10:35 AM 2005 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Month, Dey, Year) | Oct. | 7, 1931 6806 Bellona Ave Baltimore The Villa 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 578-42-846 / Usual Residence of Decedent Director Washing ton, 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 Yes 2 No Be Completed by Funeral Director Baltimore MIMOL 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? DCHONA HVENUE 21212 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WLIFE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ReligiON Religious 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 and 2 should be Health and Mental leresa A. Miller 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Religious 20b. Place of Disposition (Name of cemetery, crematory or other place) E. Northern Parkway Balto, mb 21239

Date | 20c. Location - City or Town, State organization 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State Occhawn Cemetery
22. Name and Address of Facility 7/20/05 Bastinone, MS 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bradley-Ashten Funcial Home, P.A. Spring 134 Willow 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 4 TVD 14ml home Examiner Be Completed by Physician/Medical Examiner 2 YVDT Diobetes mellitus or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown To the Funeral Director: Aftar this certificata has been signed by complately filled in by tha funaral director, paga 2 should be data 24b. Were autopsy findings available prior to completion of cause 24a. Wes an autopsy 1 ☐ Yes 2 ☑ No 1 Yes 2€No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigetion 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours e To the Funeral D 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) mon-Por Kitung In no 031865 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Gutan street Baltimore 206 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature JUL 1 8 2005 Registrar

DHMH 16 Rev 6/95

		State of Maryland / Departm	·	lygiene
Physici	an	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)	2. Date of Month.	
/Medic Examin Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	City, Town, or Location of Death Standard Year If Under 24 Hrs. 8. Date of this Days Hours Min.	Day, Year) Country)
D	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Carroll Westminste		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
be filed within 72 hours after death with the Maryland tal Hygjene. ad other than "natural", or Itema 23a or 28a-f show event, if a Medical Exertiner! and the notified at	by Funeral Director	205 St. Mark Way #120 11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Never Married 2 □ Never Married 2 □ Never Married 1 □ Never Married 2 □ Never Married 1 □ Never Married 2 □ Never Married 1 □ Never Married 2 □ Never Married 1 □ Never Married 2 □ Never M	21158 ecedent of Hispanic Origin? (Specify Yes or specify Cuban, Mexican, Puerto Rican, etc.) es 2 X No Specify:	10g. Citizen of What Country? United States No-
- 3	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th 16a. Decedent's Loughier (Give kind of life. DO NO NO NO NO NO NO NO NO NO NO NO NO NO	f work done during most of working T use retired)	16b. Kind of Business/Industry State Of MD
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Italy	To Be C	17. Father's Name (First, Middle, Last) William W. Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	18. Mother's Name (First, Mid Grace Elizabe ress (Street and Number or Rural Route Nu	th Lake
Pages 1 and 2 nent of Health ant: If item 27 ury or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetery, crematory Woodlawn Cen	m. 7/20/2005	20c. Location - City or Town, State Woodlawn, MD
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	e and Address of Facility er-Queen Funeral Hom W. Old Liberty Rd. W mode of dying, such as cardiac or respirator	te and Crematory, P.A. Sinfield, MD 21784 Approximate Interval Between Onset and Death
/Medical Examiner /Medical Examiner he priviletransit	Ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	teast failed teasts	Le hrs
The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ic pregnancy r (specify)	23d. Date of delivery Month Day Year
w requires that been signed b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying the state of the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting the significant conditions contributing the significant conditions conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions conditions contributing the significant conditions conditions conditions		id tobacco use contribute to the cause of death? □ Yes 2 □ No 3 □ Probably 4 🕵 Unknown
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nding Physician: Thith. :: After this certificate e funeral director, pag	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 Xo 27. Manner of Death 1 Xolatural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		ly one) esidence 6 □Other (Specify) be how injury occurred
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, face building, etc. (Specify)	City or	n (Street and Number or Rural Route Number, Town, State)
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occur on the basis of examination and/or investigation and manner stated.	red at the time, date and place, and due to to to to to in, in my opinion, death occurred at the tin	he cause(s) and manner as stated. ne, date and place, and due to the cause(s)
To the within To the Comple	×	29b. Signature and title of certifier Capians Hard	29c. License number D S1705	29d. Date signed (Month, Day, Year) 07-16-2005
1041		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m. PANSURIVA 349 mm DR	, Westminstell	-, mD 21157
Sta Registr		31. Date filed (Month, Day, Year) JUL 1 8 2005 32 Begistrar's Signature	()	

	1 - State Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. No	2005 2328				
cian dical diner	Virgie Iola Cox 4a Facility Name (If not institution, give street and number) Citizens Nursing Home	4b.,City, Town, or Location of Death	July 9 4c.	Year 6:10 An County of Death Har ford				
al or	5. Social Security Number 6. Sex 197-12-1825 Usual Residence of Decedent 7. Age (In yrs. last birthd: 7. Age (In yrs. last birthd: 95 Yrs	ay) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	3. Date of Birth (Month, Day, Year) apr 24, 19	Birthplace (State or Foreign Country)				
To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or MD Harford Be 3 10e. Street and Number 10c. City, Town or	L Air	10a, Cit	10d. Inside City Limi 1 ☐ Yes 2 ☑ N izen of What Country?				
ral Di	415 Market Street	21078		USA				
by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri □ Yes 2 No Specify: 	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: white				
Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	reedent's Usual Occupation ive kind of work done during most of working e. DO NOT use retired)		ind of Business/Industry				
To Be Co	17. Father's Name (First, Middle, Last) Thomas Henry Hash		First, Middle, Maiden	,				
	French Peak/sister 5 H	ailing Address (Street and Number or Rural is Opewell Road Havre disposition (Name of Da	e Grace, N	ID 21078				
ni	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	grematory or other place)	23312	ocation - City or Town, State				
	Ronald S. Wade Virgetor	22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201	655 W. Bal	timore Street				
n I	23a. Part 1. En er the disease, or 3 mplications that caused the death. Do not shock, or 0 art failure. List only one cause on each line. Immediate Cause Final disease or condition resulting in death) a	enter the mode of dying, such as cardiac or a	respiratory arrest,	Approximate Interval Between Onset and Death				
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Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		23d. Date of delivery Month Day Year					
by	Part II. Other significant conditions contributing to death but not resulting in the		acco use contribute to the cause of death?					
Completed	,		24a. Was an autopsy performed? 1 Yes 2500	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No				
tlon; To Be	25. Was case referred to medical examiner? 1							
Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)							
Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de and manner stated. Certifying Physician: To the best of my knowledge, de and manner stated.	r investigation, in my opinion, death occurred	at the time, date and	place, and due to the cause(s)				
Me	29b. Signature and title of certifier Www. *10	29c. License number D32G09 De. Print) Revolution St Han	29d. Dat	e signed (Month, Day, Year)				
11								

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

COX, Virgie I.
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. Amend 1tem 19a per fh 8845 7-16-05 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 0 0 5 . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** DAVID LEE CLARK, SR. JULY 13 8:30 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 4308 RIDGEWOOD AVENUE BALTIMORE CITY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **№** M 2□ F Yrs. Director 09/23/1931 VIRGINIA 230-34-4282 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b County 10d. Inside City Limits 10c. City, Town or Location iral", or Itams 23s or 28a-f show Examiner must be notified at 1**X**Xes 2 ☐ No Director N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 4308 RIDGEWOOD AVENUE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced "natural", BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AUTO MECHANIC A.D. ANDERSON 6ТН 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **EDWARD** CLARK PEBBIE CLARK 19a. Informant's Nam Pelatragano (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS DAUGHTER / DAUGHTER 4308 RIDGEWOOD AVE, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 7/19/05 MD NATL MEM PK LAUREL, MARYLAND 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signatur any ir 4600 LIBERTY HEIGHTS AVE., BALTIMORE, and the release, or complications that caused the de rock, wheat riture. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Impedia Cause (Final disease or condition resulting in death) **Physician** months Luna /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) eun 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? certificate 1 ☐ Yes 2 No 1 Yes 2∏ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation M 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: Diractor: 24 hours a the

> State Registrar

Medica

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hallarman 31. Date filed (Month, Day, Year) JUL 1 6 2005

3900 Lock Raven 32. Sistrar's Signature

DHMH 17 Rev 1/2001

2

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

[Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

[Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

13/06

00055033

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	Marylan	•	artment			ind M	ental Hyg	-	200	5	23287
	Dhysisi		1. Decedent's Name (First, Middle, La	ast)							2. Date of Dea Month			ear	3. Time of Death
5	Physici /Medic		BERTHA O	XDN							JULY	13	20	05	2)00 M
1	Examin	er	4a. Fecility Name (If not institution, gi		or)		-		LSTU		1		County of 1		205
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	Aanyla Fehor	ō	MD 100. County		100.01	Baltim									0d. Inside City Limits ty□Yes 2□No
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	7 with	a D	623 S. Port Stre	eet				2122	4				USA		
	ame ame	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13. \	Nas Deced	ent of His	spanic Orio	jin? (Spe	cify Yes or No- Rican, etc.)		14. Race - / Black, V		
36	or it	by Fu	1 Never Married 2 Married	1 Tes 2 If Yes, Give Year or Date	X No		1 ☐ Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	, 5,5,7		Specify:		
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215	within 72 hours after death with the Maryland ene. Han "nature!" or iteme 23e or 28e-f ehow the Medical Examiner must be notified at	Completed	(Specify only highest gi Elementary/Secondary (0-12)		0(5+)	(Give	kind of wor DO NOT us	k done d	uring most	of worki	ng	100.10	IG OF BUSHI	033/1110	ustry
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Z Z	and 2 sho saith and n 27 te m		Mr. Robert Dixon								Route Numbe				-
ē,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition			Place of Dispo	sition (Nam	e of	urive	EII	icoot C	20c. Lo	cation - Cit	y or To	wn, State
altimore,	Pages nent of I ant: If it		1 TyBurial 2 ☐ Cremation 3 (1 ☐ Donation 5 ☐ Other (Spec		ate Sp	ringfi	eld C	emet	ery 7	/19/	2005	Syke	esvil]	le,	MD
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Patturel', or itame 23e or 28e-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Lice	2. Ha	126	H. S	AIGHT vkesv	Addres FUN	s of Facility ERAL MD	HOME 2178	& CHAP 4 (410)				
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) 1	nysician		Immediate Cause (Final disease or condition	, ACUTE		YOLAG									Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseq										
		- La	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseq	uence of);								-	
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oʻ	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or	as a conseq	uence of):								\top	
8760,	Attending Physicien: The law requires that the death certificate be executed to death. The death of death to certificate has been signed by the attending physicien and ector. After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	dicai	•	d											
9 x	it the death certific: by the attending pl lached for use as t	Physician/Medi	IF FEMALE:	23c. If yes, outco	me of pregna	ancv						Τ,	and Date of	anna an a	
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	To th within To th	Me	29b. Signature and title of certifier	Α			29c.	License	number		2	9d. Dat	e signed (M	fonth, E	Jay, Year)
			· Cafford of	Mr. m	つ		10	002	2497	D		JUI	LY 15	, 2	005
	3		30. Name and address of person who CLIFFDRD FRAGA.	completed cause	of death (Item		Print)				5 DWr	v /	220	r a	2)133
	Sta Registr	100	31. Date filed (Month, Day, Year) JUL 1 8 2	795 32.	istrar's Signa	ature)			
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DHMH 17 Rev 1/2001

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	Physici	an	Decedent's Name (First, Middle, Las I NA)	וח	EMARIO		2. Date of Dea		Year	3. Time of Death 11:05 AM	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			or Location of Dea		4c. County	of Death	11100 //	
			9330 FITZHARDING		to an binds at a si	OWII	NGS MILLS			2 D: #	BALTIMORE	
ı	Funeral Director		5. Social Security Number 6. Security Number 11	7. Age (In yrs.	Yrs.	Months Days	Hours Min		954	9. Birthp Coun	lace (State or Foreign try) MD	
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	with the	Dire	10e. Street and Number 9330 FITZHARDING	LANE		10f. Zip Code	117		10g. Citizen of W	hat Coun	try?	
	ms 23	neral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.			Specify Yes or No- rto Rican, etc.)			an Indian,	
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Division	lor Attai after des Diractor in by the	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, st ify)	reet, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	or Or Rura	l Route Number,	
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	0	29a. Certifier Certifying Ph	ysician: To the best of my kn	owledge, deat	h occurred at the t	ime, date and place	e, and due to the	cause(s) and ma	nner as st	ated.	
	To the Hospital within 24 hours a To the Funaral Completely filled	edic	(Check only 2 Medical Exam	iner: On the basis of examinand manner stated.	ation and/or in	vestigation, in my	opinion, death occ	curred at the time,	date and place, a	ind due to	the cause(s)	
	To Toon	×	29b. Signature and title of certifier			29c. Licen	277 <i>3</i>		29d. Date signed			
i	7		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,				7/13/05 none 40 21204			
į.			GAMY CONEW	49 65-69		HARLES	17. B	4 Mayor	E 40	1 2	1204	
	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 8 200	32. Registrar's Sign	-9	Ma)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 3:16 AM serral Davis 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital Baltimore Harbor 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days 1₩ M 2□F 54 Yrs. Director 216-56-5013 Feb 18, 1951 Usual Residence of Decedent iit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland timent of Health and Mental Hyglene. It intent of Health and Mental Hyglene ritant: If tem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it a Midfical Expression must be notified at 10a. State 11nk 10b. County unk 10c. City, Town or Location 10d. Inside City Limits unk | Yes 2 No Director unk | 10f. Zip Code unk 10e. Street and Number 10g. Citizen of What Country? unk Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No black. Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harbor Hospital 3001 S. Hanover Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 NOther (Specify) in state perrit.
Dep rtm
Importa
any inju 21. Signature of Funeral Service Rop 11d 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hyponatremia Physician 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Alcoholism fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Medicai Examiner burial-transit Due to (or as a consequence of): IF FEMALE

The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records, Hospital or Attending Physician: filled in by

Baltimore, Maryland 21215-0036

hysician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3 □Ectopic		23d. Date of delivery Month Day Ye.	ar	
Completed by Pl	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	g cause given in Part I.	23e. Did tobacco use contribute to the cause of dea 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ ✔ €	ath? known	
					24a. Was an autopsy performed? 1 Yes 2 10 40 Yes 20 10 Yes	ailable ise of	
Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
2	1 ☐ Yes 2 € No	Hospital: 1 Impatient 2	ER/Outpatient 3	OOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)		
atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 Pes 2 No	28d. Describe how injury occurred		
Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		ory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)	∌r.	
<u>a</u>	29a. Certifier 1 Certifying Ph	ysicien: To the best of my kn	owledge, death occurre	ed at the time, date and plac	e, and due to the cause(s) and manner as stated.		

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Baltimore

29c. License number

RES 000

19/2005

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bassel Alkhalil South 3001 Hanover Street 31. Date filed (Month, Day, Year)
JUL 1 8 2005

BasselAlkhalil

and manner stated

house officer

DHMH 17 Rev 1/2001

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DELANG BARBARA

			1- For State of Maryland / [Department of Hea Certificate of De		Il Hygiene	100	23291
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	Examir Funeral	er	4a. Facility Name (If not institution, give street and number) Hely Hedical Coulum 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	Months Days H	UULU Under 24 Hrs. 8 Dat	e of Birth	County of Death	thplace (State or Foreign buntry)
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	death with the Maryland ims 23a or 28a-f show ir must be notified at	Director	10e. Street and Number	ALTIMORE 10f. Zip Code		10g. Cit	tizen of What Co	Yes 2 No Duntry?
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o	tending Physician: Th teath. tor: After this certificate the funeral director, pag	To Be		itpatient 3 DOA Other: 4 Time of njury at Work?	Place of Death (Check University Home 5 28d. De			city)
Division	tal or Attending rs after death. at Diractor: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		28f. Loc	ation (Street and or Town, State		iral Route Number,
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)	1 2 2 8		Faren a Kyzka	40 D40	0744	<u>Ju</u>	ly 16,	2005
	Sta	ite	30. Name and address of person who completed cause of death (Nem 23a) in the house of the house	V Conter	301 S	to more,	aul	21202
	Registr		JUL 1 8 2005 Street &	Locale				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician Eckstein** A^{M} July 16. 2005 6:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dundalk Genesis Eldercare - Heritage If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) March 30, 1921 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2**X**☐ F 213-14-3949 84 Director MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23s or 28s-1 show or other treumstic event, the Madical Examinar must be notified at 1 Yes 2 No Director MD. Baltimore Fort Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9302 Todd Avenue P.O. Box 193 21052 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If tiem 27 is marked other than "natural", or ite: 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 8 vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albina Jagielska Louis Macek 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21052 19a. Informant's Name/Relationship (Type, Print) 9302 Todd Avenue, P.O. Box 193, Fort Howard, Alvina Danna 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State o # 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: if any injury or once. Gardens Of Faith Cemtery July 19, 2005 Rosedale, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²²Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers POint Road, Dundlak, MD. 21222 23a. Part1. Enter the disease, of complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Visyonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MLAK Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav 5 ☐ Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 99 1 Yes 2 No 3 Probably 4 Minknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 Yes 20 No 1 Yes To the Hospital or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Af 2 No 1 Tyes 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ame and address of person who completed eadse of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** canette /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7849 BX 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1 M 2 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 tes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 900 A2cor Itams 23a Completed by Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Forces? permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or Itar may Injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married 1 ☐ Yes 2 █ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Dividowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 19 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Ruraf Route Number, City or Town, State, Zip Code) 20877 19b. Mailing Address (Street and Number of 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 1 Burial 2 Teremation 3 Removal from State 5 ☐ Other (Specify) ¹ 4 ☐ Donation After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. proximate Interval Between Onset and Death mmediate Cause (Final HISTORY BRANN Priysician disease or condition resulting in death) /Medical Examiner FALLUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto (or as a nonsequence of) Examiner burial-transit CHF Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 3 Probably 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan certificate has 2[6 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 2 1 🗌 Yes 27010 4 Unursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; within 24 hours after death. To the Funeral Diractor: After 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier I 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D004795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLL HOUSE AVE . FREDERLICK DIBTE A FARMI, MID 814

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 8 2005

32. Raistrar's Signature

John Fries 05-04583 RPD

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	/Medic	al	John Thomas Fri 4a. Facility Name (If not institution, give			4b City Town or	Location of Death	July 7	, 2005	0957 PM
	Examin	ier	3701 Northpoint R			Dunda1k	Cocation of Death		Baltimo	
Ī	Funeral Director		5. Social Security Number 6. Sec		ge (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, 5/26/19	9. 49 M	Birthplace (State or Foreign Country) laryland
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			MILFORD MANOR N						10RE				ALTIMO	
	Funeral Director		5. Social Security Number 6. S 217–12–3899	ех □м 2 ∏ F	r. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Months [Days	Hours	Min.	8. Date of Bir (Month, Da JUNE 1	y Year) 5, 19	9. Bir	thplece (State or Foreign ountry)
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	4		30. Name and address of person who	completed cause	of death (Item	1 23a) (Type.	D. W		690				114	05
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	Sta Registr		31. Date filed (Month, Day, Year)	2005	strar's Signa	J. J.	bethe							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1			1- State of Maryland / D 1- State Amend Item 1&Unpend Item 23a, RegistrarAmend Item I per me G847	epartment of Health and Ment Sertificate BFD met 6846_8-	al Hygien 31-05 tasreg. N	2005	23297
	Physici	an	Decedent's Name (First, Middle, Last)	2. D	ate of Death fonth D	ay Year	3. Time of Death
No.	/Medio	al	George Howard Garner IV IV 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		2, 2005 lc. County of Death	8:15 A M
-	Examir	er	Chesapeake Bay near Manorwood Shoal			Baltime	
T	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		ate of Birth Month, Day, Yea 2-3-1959		place (State or Foreign untry) PA
5	Director		Α 43	rs. Notice Bays Hours 12	2-3-1959	9	PA
) =	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	Mary -f sh	tor	PA Chester Valle	y Township			1 Yes 212 No
	death with the Maryland me 23a or 28e-f show First the notified at	Funeral Director	10e. Street and Number 180 St George Rd	10f. Zip Code 19320	10g. C	Citizen of What Cou USA	intry?
980	after or ite	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②▼No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes XX No Specify:	'es or No- , etc.)	14. Race · Amer Black, White Specify: Wh	, etc.
5-0	"naturel",	Completed	15. Decedent's Education 16a. I (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/li	ndustry
12	withir ene. then	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	Business Owner		Concre	te
d 2	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First	t, Middle, Maide		LE
lan	uld be Aenta rrked ric ev	ToB	George Howard Garner III	Marie Ford	inio		
Maryland 21215-0036	s 1 and 2 should be filed within Mealth and Menta Hygiene. Item 27 is marked other then other treumatic event, item Me			Mailing Address <i>(Street and Number or Rural Rou</i> ll Conestoga Rd, Frazer,		or Town, State, Zi 355	ip Code)
Baltimore,	Pages 1 a nent of Hes int: If item iry or othe		I L Dollar 2 (2 Cremation 3 Linemoval Rolli State)	Disposition (Name of crematory or other place) ew Crematory July 16,		Location · City or T Baltimor	
Balti	permit. Pages Department of Important: If i eny injury or o		21. Signature o Funeral Service Licersee	426 Crain Hwy SW, Glen Fink Funeral Home, P.A		, MD 210	61
1	Physician /Medical Examiner		23a. Part i Enter the disease, or combilications that caused the death. Do no shock or heart failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Drowning Due to (or as a consequence of	it enter the mode of dying, such as cardiac or resp	aratory arrest,		Approximate Interval Between Onset and Death
68760,	ificate be executed g physicien and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of Cause Co				
587	tificate be e ig physicien as the buria	edical	d.				
P.O. Box (ne death cert the attendin thed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	ery Day Year
ds, P	uires that tl signed by Id be detac	ğ	Part II. Dther significant conditions contributing to death but not resulting in t	he underlying cause given in Part I. 2.		. /	the cause of death?
Vital Records,	ne jaw require has been sig ge 2 should b	Completed		2	4a. Was an autopsy performed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
e		e Co	25. Was case referred to medical		Yes 2□N	o 12 Yes	2□ No
S	Physicien: this certifice ral director, i	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outp	26. Place of Death (Cheratient 3 DOA Other: 4 Nursing Home 5		6 Other (Sacr	to at scope
οt	ding Phys h. After this funeral di	n: T	27. Manner of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injury at 28d. D	escribe how inju		m at scelle
ioi	oat De:	atic	Accident investigation round rou		ect Dro	wned	
Division	Hospitel or Attended Hours after deatle Funerel Director Stelly filled in by the	Certification:	3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined building. etc. (Specify) Scene	Ci			ake Bay Sout Chase, Md
	To the Hospitel or Att. within 24 hours after de To the Funerel Direct. completely filled in by it	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the Dest of my knowledge, 2 Medical Examiner: On the basis of examination and/	death occurred at the time, date and place, and du	ie to the cause(i	c) and manner ac o	stated
	To to to to to	Σ	29b. Signature and offe of ceptifier	29c. License number	29d. Da	ate signed (Month,	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (T		Jı	uly 13, 2	.005
			FAM SOUTHALL, MS	111 Penn Street	Baltimo:	re, Maryl	land 21201
	Sta • Registr		31. Date filed (Month, Day, JUL 1 8 2005 Register's Signature	Sperke			

			For State	State of M		artment of Health a	•	20	0.5	00000
			Registrar 1. Decedent's Name (First, Middle, Las		Ce	rtificate of Death	2. Date of De	Reg. Ng.	0.0	3. Time of Death
	Physici		TRENE	•/	GI	ANNAS	Month	Day	Zoo5	10: 5-6P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of			nty of Death	,
					MEDICAL CENTER					
	Funeral Director		220-02-1921	9X 7. Ag	e (In yrs. last birthday, 73 Yrs.	If Under 1 Year If Under 1 Months Days Hours	Min. 8. Date of Bir (Month, Date of Bir (Month	ay, Year)	9. Birthp	ace (State or Foreign ry) 7RCCCC
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L				11	Od. Inside City Limits
	8e-f sl	ector	MD		Balti					1 PYes 2 No
	s with th	Dir	10e. Street and Number	Street		10f. Zip Code		10g. Citizen o	of What Coun	try?
	ems 2	inera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Orig If Yes, specify Cubap, Mexican	gin? (Specify Yes or No. Puerto Rican, etc.)		ace - America	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23e or 28e-f show or other treumatic event, "Item Medical Evantary Items Items John Items or other treumatic event, "Item Medical Evantary Items It	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 Yes If Yes, Give Year or Dates:	N o	1 Yes 2 No Specify:	,	1	city: Wh	
21215-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occupation kind of work done during most	of working	16b. Kind of	Business/Inc	lustry
121	within ene. than "	Jdmc	Elementary/Secondary (0-12)	College (1-4or	life.	tomemaker		00	UN A	lome
1d 2	e filed Il Hygid other	Be Co	17. Father's Name (First, Middle, Last)				r's Name (First, Middle,			
Maryland	ould be Mental Parked c	ToE	Sty LIANOS M.			Than	ENI YDS	silan	tis	
Mar	d 2 sho th and 7 is m treum		19a. Informant's Name/Relationship (7	Type, Print) IAS - 501		ng Address (Street and Numbe	. 11			_
	es 1 and of Health fitem 27 rother tr		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place)	ve Hoing		n - City or To	21009 wn, State
<u><u>E</u></u>	Pages ment of ent: If its ury or o		1 Surial 2 Cremation 3		Oak L	awn J	Wy 15,2005	Balhi	MORE	mb
Baltimore,	permit. Pages Department of Importent: If i any injury or o		21. Signature of Funeral Service Licen	0 m	2	2 Name and Address of Facility Bradley-A3h 2134 Willow	ton Funer	eal Hon	ne P.1	9.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each li	the death. Do not en					Approximate Interval Between
P	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		T Cris	S				Onset and Death Tokany S
	Examiner		ſ	Chron	a consequence of):	logenous	Levker	mi a	2	5 400
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence on:	10901003	L EO NO	7114		(Ed)
-6	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
8760,	te be e	dicai E	· · ·	d					H	
9		Med	IF FEMALE:							
). Box	ne death certifica the attending phaned for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			Date of deliver Month	y Day Year
P.0	that the di	/ Phy	Part II. Other significent conditions or	ontributing to death b	ut not resulting in the u	nderlying cause given in Part I.	23e. Did to	obacco use co	ntribute to the	cause of death?
rds,	sign sign	ed by					11	res 25 No	3 🗆 Proba	bly 4 Dunknown
Record	e law has b	Completed			<u> </u>		24e. Was autop perio		. Were autop prior to com death?	sy findings available pletion of cause of
Vital		0	25. Was case referred to medical			26 Place	1 ☐ Yes of Death Check on o	200 No	1 ☐ Yes	No No
<u>></u>	8 8	To B	examiner? 1 Yes 2	Hospital: 1 Mopatie	ent 2 ER/Outpatier	04	sing Home 5 Resid		ther (Specify,	
Division of	ding After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time o	f 28c. Injury at Work? M 1 Tyes 2 N	28d. Describe h	now injury occu	urred	
Divis	5 g g c	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc	ury - At home, farm, str c. (Specify)	reet, factory, office	28f. Location (5 City or Tox		nber or Rural	Route Number,
	Hospite 4 hours Funerel	edical C	29a. Certifier (Check only one) Certifying Physical Example (Check only one)	iner: On the basis of	f examination and/or in	n occurred at the time, date and vestigation, in my opinion, death	place, and due to the of occurred at the time, of	cause(s) and n	nanner as sta , and due to	ted. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner sta	ated.	29c. License number		29d. Date sign	ed (Month, D	ay, Year)
)	4		1 May o	are me	0	RES - 000		Jaly 12	200	5
1	0		30. Name and address of person who of MICHAEL CANE, MD	JOHNS H	OPKINS BAY V	Print)	1774 424	C 4-1	,	5 Beltimere HD
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1 MA	MILK 4-540	s enster	N THE,	ZIZZA
	Registr	31	./// 182	005 Make	in D. A.	200				

		State of Maryland / Dep	partment of Health and Mertificate of Death	1ental Hygie	
Physicia /Medica	al .	1. Decedent's Name (First, Middle, Last) Richard Graf	4h Chi Taun ay bashing (David	2. Date of Death	Day Year 2005 3. Time of Death 1:30 PM N
Examine Funeral Director	er	4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice 5. Social Security Number 126-48-5393 1	4b. City, Town, or Location of Death Baltimore // If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sept 11,	4c. County of Death 9. Birthplace (State or Foreig Country) 1958 New York
e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Harford Abing			10d. Inside City Limits 1 □ Yes 2√1 No
th with th	al Dire	10e. Street and Number 3502 Thomas Point Court #3B	10f. Zip Code 21009	10g.	Citizen of What Country? USA
within 72 hours after death with the Maryland ene. than "natural; or Items 23a or 28a-f ehow the Medical Evantinar must be notified at	by Funer	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
within 72 ho lene. than "natura the Wedicel	Completed by Funeral Director	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	unk 16t	b. Kind of Business/Industry unk
tould be filed I Mental Hyg narkad other natic event,	To Be C	17. Father's Name (First, Middle, Last) Richard Graf	Diane H		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		William Graf/brother 914 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	ling Address (Street and Number or Rure Inwood Terrace Jac rosition (Name of ematory or other place)	ksonville	
permit. Pa Departmen Important: any injury once.			22. Name and Address of Facility tate Anatomy Board altimore, MD 2120	655 W. B	altimore Street
Physician /Medical			nter the mode of dying, such as cardiac c	or respiratory arrest,	Approximate Interval Between Onset and Death
(e) be executed (c) (c) (c) (c) (c) (c) (c) (c) (c) (c)	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	IV		20grs
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
uires that n signed b	ò	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Unknow
elcian: The law requir s certificate has been si lirector, page 2 should	Completed	Circhosis ol		24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
th. After this certific funeral director,	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No		n (Check only one) me 5 ☐ Residence 28d. Describe how in	
To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	City or Town, St	
the Hosp thin 24 ho the Fune mpletely fi	Medical	29a. Certifier (Check only only) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	nvestigation, in my opinion, death occurre	ed at the time, date	and place, and due to the cause(s)
Viii TO TO	,		29c. License number D 13006		Date signed (Month, Day, Year)
State Registra	•	30. Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) 32. Registrar's Signature	W. Read St	, Balt	1/12/05 6. Md. 212

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July **Physician** Ruby Campbell Hare 6:50 а м /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LongView Nursing Home Carroll Manchester 8. Date of Birth
Month Day Year) 927 5. Social Security Number 212-26-7463 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 ☐ F Carolina Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23a or 28e-1 show any Injury or other treumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Carroll Manchester Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3240 Farm Lane 21102 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ѽ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Beauty Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James L. Campbell Mary Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3250 Farm Lane, Manchester, Md. 21102 Mark Miller - grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State New Lutheran Cem. July 20,2005 Manchester, Md. ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensei 22. Name and Address of Facility Ckhardt Funeral 296 Charmil Dr. Chapel P.A. Manchester, Ellen Farth Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician eer s /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): ettending physician for use as the burial P.O. Box 68760, IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregn in the past 12 mores?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) ned by the 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 1 🔲 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes 2 No 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 6 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification; To 1 Tes 2 ER/Outpatient 3 DOA completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1. Natural efter death. 1 Tes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide vithin 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State JUL 1 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a.pt.II per meo 845 7-18-05 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 8:15 PM **Physician** 2005 10 Lillian B. Hill /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Buttimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Health Care Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F 80 Yrs. 220-18-4551 11-26-1924 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ns 23a or 28a-f shov 1X Yes 2 No Baltimore Directo MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 USA 1922 Woodside Avenue Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 11. Marital Status Black, White, etc. other than "natural", or Iten vent, the Musical Examinar filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify þ 3 XWidowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse 11 Healthcare 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othing any injury or other traumatic event, 900. 17. Father's Name (First, Middle, Last) Be Louise Brown 2 Norman Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Andre T. Brown/Son 1922 Woodside Avenue Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 07-14-05 Baltimore, MD * 4 □ Donation 5 □ Other (Specify) Baltimore National Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4 days **Physician** Disorder Seizur /Medical Due to (or as a consequence of) **Examiner** Anothe Brain Sequentially list conditions, sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year been signed by the atter should be detached for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💋 Unknown **GERD** 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe has page 2 2 No certificate 1 Yes of Vital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by the funeral 27 Manner of Death 28b. Time of 28d. Describe how injury occurred After : Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a To the Funeral I To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jamach MO 17600 July, 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9005 aton Avenue, Billinore, MD 21229 MITIKIRI, NIZUPAMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 8 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	S	tate of M	Maryland	-	artment rtificate				lental Hy		005		23303
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_	and 2 sho alth and 127 is ma er treums		19a, Informant's Name/Relationship (Type MICHELE HOWARD/MO)	oe, <i>Print)</i> THER		-	and Number or Rura AVE. BALT		r, City or Town MARYLAN		
$\mathcal{H}_{\mathcal{O}_{\mathcal{C}}}$ Baltimore,	Pages 1 and 2 nent of Health int: If item 27 I iry or other tre		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	20b. P	lace of Dispos	ition (Name of atory or other pla	SPT ON	ate	20c. Location	City or To	wn, State
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ALBERT HOFFMAN 05-03787 RKD

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This property is a state of the cause of death (Item 23a) (Type, Print) ANA RUBIO MD. State 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	UQ.	D 0 0	tlon	1 □Natural 5 □ Pending	Found th, Day Yea	r) 280. Tin				da. Describe no	w injury occui	red	unk	
This property is a state of the cause of death (Item 23a) (Type, Print) ANA RUBIO MD. State 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	/ISI	Attender deat	flca	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm				8f. Location (St	reet and Numi	ber or Rura	<u>vi</u> Ro <u>u</u> te Number,	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the cause (s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO MD. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	á	- 9	Certi	4 Homicide	Dulldling, atc. (St	ecify)				City or Town	^{i, State)} Mai	rvland	i Genera	il
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO MD. 111 Penn Street Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year)		a Hospit 24 hour a Funere etely fille		(Check only 2X Madical Exan	ninar: On the basis of exar	knowledge, onination and/o	eath occurred at to or investigation, in	ne time, date a my opinion, de	and place, ar	nd due to the ca	use(s) and m	anner as s	tated.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO MD. 111 Penn Street Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year)		To the To the compl	Me	29b. Signature and title of certifier			29c. Li	cense number	r	25	9d. Date signe	ed (Month,	Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO MD. 111 Penn Street Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				> Uno	<			OCME			JUNE 3.	2005	5	
State 31. Date filed (Month, Day, Year) 22. Registrar's Signature					completed cause of death	(Item 23a) (Ty		Penn St	reet					1
Registrar JUL 1 8 2005 April 1					32. Registrar's S							-		

Charles Henry 05-3446 AKG

140			For State Registrar	State of Man		artment of F			ene 2005	23306
	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Charles Henry						2005	11:30 A M
	Examin	er	4a. Facility Name (If not institution, give s	,			r Location of Death		4c. County of Oeath	ı
			3700 West Belveder 5. Social Security Number unk 6. Sex		In yrs. last birthday)	Baltime If Under 1 Year		8. Date of Birth	o Righ	nplace (State or Foreign
	Funeral Director		1∑	AM 2DE	56 Yrs.	Months Days	Hours Min.	Jan 26,	Year) Cou	unk
	ס		Usual Residence of Decedent					Jun 203		
	show	_	10a. Slate unk 10b. County	unk 1	0c. City, Town or Lo	ocation				10d. Inside City Limits unk⊓ □ Yes 2 □ No
	the M	Director	10e. Street and Number			k 10f. Zip Code		1 ₋ 10	g. Citizen of What Cou	
	With With		Too. Street and Humber		un	K 101. Zip Code		unk 10	USA	nu.y:
	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show ideal Examinar must be notified at	Funerai	11. Marital Status unk	12. Was Decedent Eve		Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
9	or Ita	큔	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	unk	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto Specify:	Hican, etc.)	Black, White	
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						lack
7-	C 9	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of worl	ing unk 1	6b. Kind of Business/!	ndustry unk
212	T the	mo	Elementary/Secondary (0-12) unk unk	College (1-4or 5+) nk			,			
b	e filed al Hygie other vent, tr	Be C	17. Father's Name (First, Middle, Last)			unk	18. Mother's Nam	e (First, Middle, M.	aiden Sumame)	unk
ylai	should be ind Mental is marked o	Tof								
Maryland	01 00 00 00		19a. Informant's Name/Relationship (Ty	pe, Print)					City or Town, State, Z	ip Code)
	1 and 2 Health tam 27		O.C.M.E. 20a. Method of Disposition		20b. Place of Disp	Penn Str	eet Balti		21201 Oc. Location - City or 1	Town State
nor			1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☒ Other (Specify)	Removal from State	cemetery, cre	matory`or other plac	CB)		.,	,
Baltimore,	+ E # E		21. Signature of Funeral Service License Ronald S. W		. 2	2. Name and Addre	ss of Facility			
m	Depar Impo any ir		Ronald S. W	lade, Direc		tate Anat altimore,	omy Board MD 2120	l 655 W.] 1	Baltimore :	Street
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused th	e death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Merro	sclent	i Cird	www	or Voi	sease	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):					
		į.	Sequentially list conditions,	b. Due to (or as a c	tunesquenes of):					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	. ,					
ó	an an		resulting in death) Last	Due to (or as a c	consequence of):					
68760,	icate be executed physician and the burial-transit	dical		d						
_		9	IF FEMALE:	20 - 11						
Вох	death certifi e attending p id for use as	Physician/M	in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	1		23d. Date of deli- Month	very Day Year
o.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ne or death 31	Other (specify)				
s, P	the de	by Pr	Part II. Other significant conditions con	ntributing to death but	not resulting in the	ınderlying cause gıv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	quires en sign							1 🗆 Yes	s 2□No 3□Pro	bably 40 nknown
Record	taw requas been 2 shoul	plet						24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
Ä	The ate h page	Completed						A perform	ed? death? □ No 1/2 Yes	2 No
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	In-mia-ti		100		th (Check only one)	
of	Phys this al dir	9	1 XX es 2 □ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	_	4 Nursing H	ome 5 Resider		ity) at scene
	ding I. After funer	tion	Natural 5 Pending	(Month, Day Y	(ear) Injury	Wor	k? Yes 2□No	28d. Describe how	winjury occurred	
Division	l or Attanding after death. Director: After I in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury				28f. Location (Stre	eet and Number or Ru	ral Route Number,
ā	Dirte	Certification:	4 Homicide determined	building, etc.	(Specify)			City or Town,	State)	
	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of e	my knowledge, dea	th occurred at the time	me, date and place	and due to the car	use(s) and manner as	stated.
	To the H within 24 To the Fi complete	Medical	9/18)	and manner state	d.					
	5 07 00 00 00 00 00 00 00 00 00 00 00 00		29b. Signature and title of certifier	Λ		29c. Licens		29	d. Date signed (Month	
7			30. Name and address of person who co	ompleted cause of don	th (Item 23a) (Type				May 19, 20	JU5
			T. CAREN LE	ME M	(Type		enn Stree	t Baltimo	re Marylan	d 21201
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature					
	Regist	rar	JUL 1 8 2005	Destar.	il poor					

			FOI	partment of Health and Me ertificate of Death	ental Hygien	A A A A A A A A A
	Q		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medio		Mary Elizabeth Jackson		July 13	,2005 5:55P M
	Examir		4a. Facility Name (If not institution, give street and number) 8433 01d Marlboro Pike	4b. City, Town, or Location of Death Upper Marlboro		c. County of Death Prince George's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Pay, Yea	9. Birthplace (State or Foreign
	p »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Marylé f eho	ō		rict Heights		to the second second to the second s
	with the hard or 28e-	Direc	10e. Street and Number 4:353 Forestville Rd.Apt. 201	10f. Zip Code 2 0 7 4 7		Citizen of What Country? United States
	eeth ne 234	Funeral		3. Was Decedent of Hispanic Origin? (Spec		14. Race - American Indian,
980	172 hours after deeth with the Maryland "neturel", or Iteme 23a or 28e-f ehow after Erechiner must be notified at	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Gre 3 Widowed 4 Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 ☐ TNo Specify:	ican, etc.)	Black, White, etc. Specify: White
5-0	72 h	etec	(Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of work in	g 16b.	Kind of Business/Industry
21215-0036	withir she.	Completed		e. DO NOT use retired) Manager	Fo	od Service
73	Hyg Hyg the int,	To Be C	17. Father's Name (First, Middle, Last) Carl Serrill Welch	18. Mother's Name Harrie	(First, Middle, Maide tt Burge	
ary	shound M	۴		ailing Address (Street and Number or Rural		
	t and 2 Health a tem 27 is		Catherine Jackson/Daughter	8433 Old Marlbo	•	
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ott	1	20a. Method of Disposition 11 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ection Cemetery	Cli	Location - City or Town, State .nton, Maryland
Balt	permit. Departr Importe eny inje		21. Signatur of Funeral Service Liberate 1. 1. Signatur of Funeral Service 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	22. Name and Address of Facility Lee $6633~01d~Alexand$		Home, INC Rd. Clinton, Md
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Pnysician	é n	Immediate Cause (Final disease or condition resulting in death)	controlallus	3	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	and to the same		
		Jer	Sequentially list conditions, if any, leading to intrinsidate cause. Enter Underlying Cause (Disease or injury	ance to taxio		
	ocuted nd transit	Examin	that initiated events c.			
8760,	e be executed rsician and e burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):	nove Cardior	ascula	direce
687	ficate g phys as the	edical	d.			
О. Вох	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/M		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	s that the ned by t e detach	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ords	w requires been sign should be	ted t			1 🗆 Yes	2 No 3 Probably 4 Unknown
l Records,	i: The law re icate has be , page 2 shi	Completed			24a. Was an autopsy performed?	
Vital	icien: certifica rector,	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	VV D
of	hys this al di	. To	1 ☐ Yes 12 1 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa 27. Magner of Death 28a. Date of Injury 28b. Tim.		e 5 🗌 Residence	
	th. : After	tlon	XXXNatural 5 Pending (Month, Day Year) Injur 2 Accident investigation		30. 5030/100 /101/ 11/	ary 5556110g
Division	ol or Attending Patter death. Director: After it in by the funer.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	Bf. Location (Street and City or Town, Sta	and Number or Rural Route Number, te)
	Hospite 4 hours Funerel	edical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place, ar r investigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complet	Mec	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
	- 5 - 0		Auna M) MD.034611	7	1505
/	1		30. Name and address of person who completed cause of death (Item 23a) (Type Aruna Paspula, MD 106 Irvit	pe, Print) ng St. #415 Washi	ngton, l)C
:-	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	40 -		
	Regist	वा	111 1 8 2005 Marin 16 Com	alle)		

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-Iransit

		Plea	se Type or						=	-	gible.	
	1 - For State Registrar		State	f Marylar		artment of <i>tificate o</i>				giene Rog. No 20	05	23308
	1. Decedent's Nam	e (First, Middle	e, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
cian lical	Donald	d Eugen	e Jablkow	ski					JULY	Contract of the contract of th	2005	700 PM
iner		If not institution	n, give street and nu		cs.\	4b. City, Town	edc.	of Death			nty of Death	
1	5. Social Security N	***	6. Sex	7. Age (In yrs.		If Under 1 Ye		or 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign
r	215-34-1 Usual Residence o		1 2 M 2 □ F	68	Yrs.	Months Day	ys Hours	Min.	(Month, Da 12/14/	1936		yland
	10a. State	10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
tor	MD	N	/A	H	Baltimo	re						M⊠Yes 2 □ No
Director	10e. Street and Nu				-	10f. Zip Code				10g. Citizen o	of What Cou	untry?
	218 S. A	Augusta	Avenue				1229				J.S.A.	
Funeral	11. Marital Status		Armed F		J.S. 13. \	Was Decedent of f Yes, specify C	of Hispanic C uban, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.))- 14. R B	ace - Amer lack, White	ican Indian, , etc.
þ	1 Never Man 3 Widowed		If Yes, G	Ve		1⊡Yes 2¥⊡1	No Specify	y:		Spec	cify: Wh	nite
etec	(Spec		t's Education st grade completed)		16a. Deced	dent's Usual Oc	cupation	st of worki	ina	16b. Kind of	Business/I	ndustry
Completed	Elementary/Seco		College (1-4or 5+)		kind of work do DO NOT use rei uck Dri			9	Per	o a i	
	17. Father's Name	(First. Middle.	Last)		1 +1	uck bii		her's Name	(First, Middle			
To Be	Stephen								eve Rog			
-	19a. Informant's N	ame/Relations	hip (Type, Print)		19b. Mailir	ng Address (Stre	et and Numi	ber or Rura	al Route Numb	er, City or Tow	m, State, Z	ip Code)
	Alexand	ria Bat	es/Daught	er	360	4 Dahli	a Lane	Balt	imore,	Mary1a	and 21	1220
	20a. Method of Dis	•	2 D	1	Place of Dispo	sition (Name of	olace)		Date	20c. Locatio	n - City or T	Town, State
	`4 □Donation		3 □Removal from pecify)		loly Re	deemer		7/1	19/05	Balti	imore,	Maryland
. Buca	21. Signature of E	neral Service	Licensee		100	. Name and Ad		OH				Son Inc.
OI .	23a. Part 1. Enter t					415 Beller the mode of a					land_	21224 Approximate
Examiner	shock, or hee Immediate Cause disease or conditic resulting in death) Sequentially list or any, wanty cause. Enter Und Cause (Disease or that initiated event	(Final Property of the Control of th	b. Met	(or as a conse	tic I	ing	se. Vi	nKns	own T	Prino	ıгу	Interval Between Onset and Death
Completed by Physician/Medical Exal	IF FEMALE: 23b. Was deceder in the past 12	nt pregnant months?	d	(or as a consection of pregree of pregree of pregree of pregree of pregree of the consection of the c	nancy tal death 3	Ectopic pregna					Date of delivery	very Day Year
lys	9 Unknowr		9□ Unkr	own								
d by P	Part II. Other signi	ficant conditi	ons contributing to	leath but not re	sulting in the u	nderlying cause	given in Pari	t I.	23e. Did t			the cause of death?
etec									24a. Was	an 241	h Were aut	opsy findings available
ошо									auto		prior to o death?	ompletion of cause of
0	25. Was case refe	rred to medica	1				26. Plac	ce of Death	Check only			20110
OB	examiner?	1	Hospital:	Inpatient 2	ER/Outpatien	at 3□ DOA	Other: 4 🗆 N	Nursing Ho	me 5 Resi	dence 6 C	Other (Spec	ify)
tlon: T	27. Manner of Dea 1 Natural 2 Accident	th 5 Pendir		of Injury oth, Day Year)	28b. Time of Injury	28c. lr	njury at Work? Yes 2		28d. Describe			
Certification;	3 Suicide 4 Homicide	6 Could determ	and 288 Plac	e of Injury - At I	home, farm, str hify)	eet, factory, offi	се		28f. Location (City or To		mber or Rui	ral Route Number,
Medical (29a. Certifier (Check only one)		ng Physician: To the Examiner: On the land man									
Me	29b. Signature and	d time of certific	<	1.4	N	29c. Lice	ense number	r		29d. Date sig	ned (Month	. Day, Year)
) He	lly ?	JWill	N M	18	DO	014	18		7115	5/05	5
	-		who completed cau	se of death (Ite	em 23a) (Type,	Print)	Sauce Ce	. Da	110 2	altina	NO	FESIS AM
tate	31. Date filed (Mor	, , , , ,		Registrar's Sign		1600	7000			, -: / / /	J. C.	

Registrar

			. For	-							lental Hygi	ene			
			1 - State Registrar			Cei	rtificate	of D	eath		_	g. No2 (105	233	09
	Physici	an	1. Decedent's Name (First, Middle, I SARAH ANNE JO	,							2. Date of Death Month	Day	Year	3. Time of	
	/Medic		4a. Facility Name (If not institution, g		mber)		4b. City, To	own orl	ocation o	of Death	JULY 1	_	0 0 5 nty of Death	2:30	- Ρ™
	Examin	er	NATIONAL INST		OF HEA	עית ד				or Dodan					
	Funeral			Sex	7. Age (In yrs.		BETI If Under 1 Months	Year Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day,		PGPMF 9. Birth	place (State or ntry)	Foreign
	Director		215-62-6847	1□M 2対F	50	Yrs.	Wichtins	Days	110013		Oct. 10	,1954		io	
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside Cit	y Limits
	Mary a-f sh	tor	Md Montgom	ery			Chevy	Chas	se					1 ☑ Yes	2 🗌 No
	or 282	Director	10e. Street and Number				10f. Zip C		_		10	g. Citizen o	of What Cou	ntry?	
	ath wi	ral	4515 Willard Ave.						815			US			
	ltams	Funeral	11. Marital Status 1 ⚠ Never Married 2 ☐ Married	Armed Fo		.S. 13. \	Was Decede If Yes, specif	nt of Hisp y Cuban,	panic Orig , Mexican	gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)		ace - Ameri lack, White,		
936	urs aff	by	3 Widowed 4 Divorced	1 □Yes If Yes, Gir Year or D	/8		1 ☐ Yes 20	X No	Specify:			Spec	city: Whi	te	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show than Madical Examinar must be notified at	Completed	15. Decedent's (Specify only highest of	Education		16a. Deced	dent's Usual	Occupati	ion	t of work	ina 1	6b. Kind of	Business/In	ndustry	······································
2	within ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work DO NOT use		, ang 111001		9				
2	filed v Hygie other t	Co	17. Father's Name (First, Middle, La	4 st)		1	Clerk	- 1	I8. Mothe	r's Name	e (First, Middle, M	aiden Sumi	F.B.I	•	
aŭ	ld be ental ked o ic eva	To Be	William L. Johne	,							Mallv				
ary	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene is marked tall Hygiene is marked other than "naturat", or Itams 23a or 28a-f show is marked other than "naturat", and the notified at aumatic evant. The Madical Examinar must be notified at	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street an			al Route Number,	City or Tow	m, State, Zip	Code)	
Σ,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Itam 27 is marke any injury or other traumatic once.		Esther M. Johnco	x/Mother					r. Po		ac, Md.				
Baltimore,	Pages 1 nent of Ho int: if Itar iry or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3	☐Removal from	State	Place of Dispo cemetery, crem	natory or oth	er place)		T117 37	16.	Oc. Location	n - City or To	own, State	
<u>=</u>	permit. Pag Department Important: I any injury o		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Mon	tgomery			umIļn	c. 20	005 Be	thesc	la, Ma	ryland	7
Ba	permi Depa Impo any i		21. Signature of Purificial Service Lite		M00798	Bei	thesda	-Che	vy C	hase	inc. Pi	7557 W	iscon	sin Av	ome/ enue
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that of	aused the deat									Approximate Interval Betw	
, 5	Pnysician	7	Immediate Cause (Final disease or condition	STR	OKE								4	Onset and D	
	/Medical Examiner		resulting in death)	a. Due to	(or as a conseq	juence of):		_	2	0.400		^		1	Ja
	Lxammer	ē	Sequentially list conditions,	b. ME	or as a consecu	470	OW	4514	4N	C	ANCEI	2		1-41	
	uted I Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(Or 43 4 CC1136C	derice or).									
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g	w require been signature should b						-				1 🗆 Yes	2 1306	3 🗌 Prob	ably 4 □U	nknown
ပို့ မ	a taw r	Completed									24a. Was an autopsy		prior to co	psy findings a mpletion of ca	vailable use of
Vital Records,	Physician: The lav this certificate has al director, page 2										perform 1 ☐ Yes 2		death?	2 🗆 No	
\(\)	Physician: this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2	EB/Outpetion	* 3 T DOA	Othor			(Check only one		where /Conneit		
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<u>S</u>	andin sath. or: Aft he fur	atlo	Natural 5 Pending investigat	on	iii, Day 19ai)	Injury	М		s 2 🗆 N	No					
Division of	al or Attanding Phy after death. I Director: After this d in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place	of Injury - At hing, etc. (Specif	ome, farm, str	eet, factory,	office			28f. Location (Stre City or Town,		nber or Rura	al Route Numb	er,
۵	pital		29a. Certifier in Certifying	Physician: To the	boet of my kno	wledge stleath	2 occurred at	the time	data and	d place	and due to the car	100/01 000		tatad	
	To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the fune.	Medical	(Check only one)	eminer: On the b	asis of examina	ition and/or in	vestigation, in	n my opir	, date and nion, deat	th occurr	ed at the time, dat	e and place	nanner as s e, and due to	tated. the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier) Ho	100	16		License r				d. Date sign	ned (Month,	Day, Year)	
	4		Mayue	VUIVIN	1 ru	xy G	1	3BC	16	35	35	,	t/(s	102	
1	0		30. Name and address of person wh				,								
	Sta	te	JOSEPH ANTHON 31. Date filed (Month, Day, Year)	32. R		10 C	ENTER	DR:	IVE,	BE	THESDA,	MAR	YLANI	2089	12
	Registr		JUL 1 8	2005	listrar's Signa	D. A	josier								

Reginald E. Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK 05-3348 State of Maryland / Department of Health and Mental Hygiene

1- For Unpend Item 23a&27 per me G846 8-8-05 tas Registrar

Registrar

Reg. Mc. AKG 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Reginald E. Johnson May 14. 2005 12:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3700 block Winterbourne Road Baltimore 5. Social Security Number unk 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑**M 2□F Yrs. Director 33 June 25, Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show 7 is marked other then "naturel", or items 23e or 28a-f shov treumatic event, 12e Medical Examinar must be notified at 1X Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 218 N. Chester Street death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: black à 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "r any Injury or other treumatic event, the Med 2018s. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 ☑Other (Specify) in state 21. Signature of Americal Service licensee Ronald Wade State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 26a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or co dition resulting in death) Pnysician No Anatomic or Toxicologic Cause of Death /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 ☐ Probably 4 ☐Unknown 2 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1X Yes 2 □ No 10 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6X Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

(Check only one)

29b. Signature and title of certifier

HARYARIN

31. Date ffled

me

· KORELO 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number OCME

29d. Date signed (Month, Day, Year)

May 15, 2005

111 Penn Street Baltimore, Maryland 21201

			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 23311
	DI		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physic /Medi		Thomas H. Johnson June 29 2005 1420 M
	Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
			Anne Arundel Medical Center Annapolis Anne Arundel
М	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country)
	Director		217-56-4506 12XM 2 F 54 Yrs. Months Days Hours Min. (Months, Day, Year) Country Usuel Residence of Decedent
	and		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Mary	ō	
	28s	Directo	Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	3a or	_	1426 Pagant Street
	ms 2	Funeral	COA
9	or ite		Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No Bleck, White, etc.
93	72 hours after death with the Maryland Instural', or Items 23a or 28a-f ehow dical Examit at most be notified at	1 by	3 ☐ Wildowed 4 ☐ Divorced If Yes, Give 970-72 1☐ Yes 2⊠ No Specify: Specify: Specify: Black
21215-0036	n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Business/Industry
121	within ene. then	ldm	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired) Future Care
2	77 77 2		11th 0 Custodian Nursing Home
anc	S e d s ≥	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ruth F. Thomas
Ž	should to nd Ment marked umatic	ို	Room B. Inollas
Maryland	2 6 9 2		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	s 1 and 3 if Health Item 27 other tra		Ruth Johnson (Mother) 1426 Regent Street Annapolis, Md. 21403 20a Method of Disposition 20b Place of Disposition (Name of Dale 20c. Location - City or Town, State
altimore,	permit. Pages Depertment of Importent: If It any injury or o		#望Burial 2 □ Cremation 3 □ Removal from State Main Main Main Main Main Main Main Main
Ē	Sermit. Pa Sepertmer mportent iny injury		'4 □ Donation 5 □ Other (Specify) Cemetery 7-12-05 Crownsville, Md. 21. Signalure of Funeral Service Licensee 22. Name and Address of Eacility 2-25.
Ba	Depermine Deperm		Wm Books St. Annapolis, Md.
1	7		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of ching, such as cardiac or respiratory agreet.
	Physician		Intervat Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):
	Examiner		Paristrum (Astania)
3		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):
	cuter nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c
Ő,	cate be executed hysicien and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	lcal	d
× 6	as as	Physician/Med	IF FEMALE:
Вох	attend attend for us	lan	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year
o.	the de	ysłc	1 Yes 2 No 9 Unknown 9 Unknown Month Day Year
P.0	The law requires that the death cer tie has been signed by the attendir bage 2 should be detached for use	Ph	Part ti Other significant conditions contributing to death by not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Vital Records,	signed d be det	d by	End Stage Pend Disconsisted to the cause of death?
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<u> </u>	has has	mp	24a. Was an autopsy findings available prior to completion of cause of
			performed? death? 1 Yes 2 No 1 Yes 2 No
	ysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No
o	Phys r this ral di	- To	1 in inparient 2 tert-Proutpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)
0	ding P th. After funera	‡	25. Address Death 28b. 1 me of 28c. Injury at 28d. Describe how injury occurred 28d. Describe
Division of	or Attending Physician: after death. Director: After this certification by the funeral director,	flca	3 Suicide 6 Could not be 28e. Place of Injury - Al home, larm, street, lactory office 28f. Location (Street and Number of Bural South Number of Bural Sout
_	al or afte 1 Dire d in t	Certification:	4 Homicide determined determined building, etc. (Specify)
	pspit hours unera y fille		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To t Com	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)
	4		153cm 6/29/05
7	1		30. Name and address of edison who completed cause of death (Item 23a) (Type, Print)
1/			While Staurine 2201 Medical Falency Annap MD 21401 31. Date liled (Month, Day, Year) 32. Resistrar's Signature
	Sta Registra		31. Date liled (Month, Day, Year) 32. Registrar's Signature JUL 1 8 2005

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State RegistramEND ITEM #19a&b PER INF C845 OF 1860 STATE OF THE ALL OF THE C845 OF TH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0825 **Physician** MAMIE JACKSON JUL 2005 /Medical 4e. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BARTIMORE JOHNS HOPKINS BAYVIEW CARE CTA N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, AUG- 17 9. Birthplace (State or Foreign 6. Sex **Funeral** 9/2/SOUTH CAROLINA Months Year) 1□ M 2**X**F 92 215-12-1731 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at BACTIMORE MD 1 Yes 2 □ No Director N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 or itams 23a STREET APT

12. Was Decedent Ever in U.S. Armed Forces? USA GEORGE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married AFRICAN. 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Completed by 3 Widowed 4 ☐ Divorced "natural". AMERICAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within then Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC WORK DOMESTIC WORK 7TH marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be find Mental I CHARLIE DAWKINS ပ္ BESSIE GLADDEN 19a Intomant's Name/Belationship (Type, Print)
LSAC MADISON (NEPHEW) 9b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
409 N. COLLINGTON AVE. 21231
920 PENNSYLVANIA AVE. APT. 2A BALTIM permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n eny injury or other traun once. 21201 2A, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/20/05 BALTIMORE CO, MD 4 □Donation \$□Other (Specify) ENTOMBMENT ARBUTUS MEM PK 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Tuneral Service Licensee 4600 LIBERTY HEIGHTS AVENUE, ter the disease, or complications that caused the death heart ailure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Intara Vears /Medical Due to (or as a consequence of): Examiner ardiovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Due to (or as a consequence of): Examiner death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 5 Other (specify) detached he 9 Unknown 9 Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 3 ☐ Probably 4 Dunknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 🗷 No certificate 2 No 1 Tyes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 2 X No 1 🗌 Inpatient 1 ☐ Yes 2 ER/Outpatient 3□ DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1.XNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation М 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide ō filled Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hipkin, Boyuse 021 Vichele 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2005

			For State Registrar	State of Mai		artment of rtificate of			Reg. N.2.	05 23313
	Physici /Medic Examir	al	4a. Facility Name (If not institution, give s	treet and number)	JR G- ==0	4b. City, Town,			Day (Year 18 05 PM yor Death
	Funeral Director		2 14440404 19	M 20 F 7. Age	(In yrs. last birthday)	If Under 1 Yea Months Days		4 Hrs. 8. Date of B		9. Birthplace (State or Foreign Maryland
	he Maryland 8e-f show offited st	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimon	[Owings	Mills				10d. Inside City Limits 1 ☐ Yes 2X No
	with ti	2	10e. Street and Number 113 Oakmere Rd.			10f. Zip Code 2111	7		-	What Country?
9036	d within 72 hours efter death with the Maryland Jiene. I than "natural", or iteme 23a or 28e-f show The Medical Examinat must be rodified at	d by Funeral		2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of	Hispanic Origi ban, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Ra	ce - American Indian, ack, White, etc.
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ryland	2 to 5	To Be (17. Father's Name (First, Middle, Last) Norbert Gregory I 19a. Informant's Name/Relationship (Ty,			a Address (Chan	Miri	s Name (First, Middle Lam Peed W	olfarth	
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Baltimore,	e = 5		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Disponentery, cred			Date 1,2005		- City or Town, State
Balt	permit. Pa Departmer Importent any injury once.		21. Signature of Funeral Service License		1	1605 Rei	stersto		ings Mi	lls, Md. 21117
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line	•			o F Lu		Approximate Interval Between Onset and Death
8760,	death certificate be executed eathending physician and of for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate based. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):		=			
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rds, P	squires than signed and be de	by	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause g	iven in Part I.			atribute to the cause of death?
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Division	or At offer of Direction by	Certification:	3 Suicide 6 Could not be determined	building, etc.				City or To	own, State)	ber or Rural Route Number,
	To the Hospitel within 24 hours of To the Funeral completely filled	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medicel Exemir	icien: To the best of er: On the basis of e and manner state	xamination and/or in	h occurred at the vestigation, in my	time, date and opinion, death	place, and due to the occurred at the time	cause(s) and m , date and place,	anner as stated. and due to the cause(s)
)	To the within To the	Me	29b. Signature and line of certifier	PHYSICI	901	29c. Licer	ise number 4272	3.	29d. Date signe	od (Month, Day, Year) 7 2005
	H		30. Name and address of person who co	L1 M-	ith (Item 23a) (Type, HARISH -	Print) NO 6	STHWE	3. Hos	RITAL ROAD.	mp 21133.
	Sta Registi		31. Date filed (Month, Day, Year)	32. Redistrar	s Signature	perte				

			Please "	Type or Print in				_	-	
			For State	State of Maryla		artment of He <i>rtificate of D</i>			e 2005	22211
			Registrar 1. Decedent's Name (First, Middle, Lasi	")		Tillicate of D		2. Date of Death	<u> </u>	3. Time of Death
	Physici		Ryong Kim					7-15-0	ay Year)5	11:40P M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or L	ocation of Death		. County of Death	
1	LAGIIII		Future Care Cente			Arnold		P	anne Arun	ndel
	Funeral		Social Security Number 6. Se	x 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	Hours Min	8. Date of Birth	9. Birth	nplace (State or Foreign untry) Korea
	Director			Z ^{M 2□F} 81	Yrs.	World S Days	Tiodis Will.	June 15, 1	924	Korea
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
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	r 28e	Director	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Cou	untry?
	h with	i D	1606 Secretariat	Dr		21	401		Korean	
9	within 72 hours after death with the Maryland liene. r than "neturel", or Items 23e or 28e-f show tre Medical Examinat must be notified at	Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2₹☐No If Yes, Give		Was Decedent of His If Yes, specify Cuban		cify Yes or No- lican, etc.)	14. Race - Amer Black, White	
8	ours rel',	d by	3 Widowed 4 Divorced	Year or Dates:		105 212110	Specify:		Specify: I	Korean
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12	within ene. than *	dm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired) ness Owner			Lounder	
d 2		ပို	17. Father's Name (First, Middle, Last)		Dusi			(First, Middle, Maide	Laundry	/
Maryland 21215-0036	ad at b	To Be	Hee Young Kim				Oh Re Ch		,	
ary.	& D E E	1	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street ar	id Number or Rural	Route Number, City	or Town, State, Z	ip Code)
	d 2 Ith a 27 Is		Kyongae Kim Goff	Daughter	526	Majestic H	Prince Dr	, Annapoli	ls, MD 2	21401
re,	of Healt of Healt f Item 2		20a. Method of Disposition		p. Place of Dispo	osition (Name of matory or other place)	Da	ate 20c. l	ocation - City or 1	Town, State
Ē	Pages nent of ont: If It ury or o		1 Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify	C	-	Memorial		05 Colu	ımbia, MI)
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Juneral Service Licens	0	Fi	2. Name and Address nk Funeral 6 Crain Hv	of Facility Home . P	.A		
	20599		K. Gregory Fin						MD 210	061
U			23a. Part Lenter the distance or color shock or heart failure list only	lications that caused the d one cause on each line.						Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	nortin	- Kear	t torilu	ne		Jeon
	/Medical Examiner		f	Due to (or as a cons	ence of):				- 13	2
L,		e	Sequentially list conditions,	b. Due to (or as a cons	sequence of):					
	nsit	ij	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsass or injury							
Ć,	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):					
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687	certificate be executed nding physician and use as the burial-transit	ledi								
Вох	eath cert attendin for use	Physician/Medical	230. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		DEctopic pregnancy		-	23d. Date of deliv	•
	0 0	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of		Other (specify)			Month	Day Year
P.O	that the de ed by the detached	Phy	9 Unknown		ht			an Diduk		44.49
Ś	res tha signed be de	by	Part II. Other significant conditions co		-	inderlying cause giver	ı ın Part I.			the cause of death?
orc	w requir been si should l	eted	- myneral C	mula dio	on.				INO SUPR	
Record	S C .	Completed	Chronic kidn	y disson	۷			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
E F		Š						performed? 1 ☐ Yes 21 ☑N	o death?	2□ No
Vital	Physicien: this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Death			
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isi	Attendir death. ctor: Al y the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	it home, farm, st			8f. Location (Street a	nd Number or Ru	ral Boute Number
Division	of or Attend after death Director: /	erti	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)	. John Marton y, annua		City or Town, Sta		
_	plte ours serel	edical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my iner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	th occurred at the time evestigation, in my opi	a, date and place, a nion, death occurre	nd due to the cause(d at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier			29c. License	number	29d. D	ate signed (Month	, Dey, Year)
	F ≯ F Ö	1	11-01	ANA		7 1.5	1521		10200	

State Registrar

31. Date filed (Month, Day, Year) 32. Re JUL 1 8 20,05

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32.5 HOS pitch & DL O LANEY

Sten Runie

32. Registrar Signature

29c. License number D -40521

29d. Date signed (Month, Dey, Year)

Fuly 18, 2005

Smite 208

21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Edwin Kotkowski 05-04668 State of Maryland / Department of Health and Mental Hygiene For State Registrar NJM Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1205 PM Kot KOWSK EdWIN Ju₁v 11 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 435 Gusryan Street Baltimore Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 100M 2□ F 213-28-7149 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other treumstic event, the Medical Example or must be notified at 1 Yes 2 No Director MDHHOM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 435 or iteme 23a 21224 USA Was Decedent Ever in U.S. Amed Forces?

1 DYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned Maryland 21215-0036 If Yes, Give Year or Dates: Kercaw lunk 1 🗆 Yes 2 No Specify: Wkite 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) lechanic RailRoad 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felix KotKowski JUDZIKOWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) + Baltimore Pages 1 and 2 ment of Health a snt: if item 27 is - Koger MA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: if any injury or once. injury or Forest Vet. Cem. July 19, 2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. -Ashton Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) atheroscleroti **Physician** cardiovascular /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine *ttending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmed? 2 No 1 Yes of Vital tor: After this certific the funeral director. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one Hospital: Other: 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Scene 27. Manner of Death 1 A latural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death 1 ☐ Yes 2 ☐ No investigation 2 Accident rector: 6 ☐ Could not be To the Hospitel or htte within 24 hours after der To the Funerel Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AC Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME July, 12, 2005 Signath (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrer amend item #26 per verb g845 Certificate of Death

1. Decedent's Name (First, Middle, Last) Reg. 20. U 2. Date of Death **Physician** Month RPP Mothers OT 29 AM 5,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NIA medilan Baltmore Herokuns Sohns If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. September 4,1921 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2□ F 216-14-7465 83 Director Yrs PA Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location Itam 27 is markad other than "natural", or itama 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at 10d. Inside City Limits MD Baltimore Director Dundalk 1 ☐ Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? with 701 Margo Road 21222 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or Ital 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 ᅙ 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Cable Operator Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anthony J. Kepp Anna Butalla 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 st Department of Health and Important: If Itam 27 is n any Injury or other traun <u>once.</u> Emma Kepp wife 701 Margo Road, Dundalk, Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 18, 2005 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Massive Hemptey disease or condition resulting in death) minude /Medical Due to (or as a consequence of) **Examiner** Sa uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nterna Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): the attending physicien the driving the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Prosta canc 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2**X**No 1 ☐ Yes 1 Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1....Inpatient 28a. Date of In Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 27. Magner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After Hospital or Attanding 124 hours efter death. Natural 2 Accident 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funaral I A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AF 266 4200H3CY JUS 15, 200T 30. Name and addr-ss of person completed cause o eath (Item 23a) (Type, Print) 10

State

Registrar

Natalyn

31. Date filed (Month, Day, Year)

WHIZE (M)

JUL 1 8 2005

32. Haristrar's Signature

4940 Ecota avenue Bettime, MD21224

		•	1 - For State Registrar	State of M	aryland	-	artmen tificate				F	10g. N2 U ()5	23317
	Physici	an	Decedent's Name (First, Middle, La	ist)							2. Date of Dea Month	Day	Yeer	3. Time of Death
	/Medic	al	Edna Kennedy 4a. Fecility Name (If not institution, given	o stead and number			4b Ciby	Town or	Location of		uly 2,	2005 4c. County	of Dooth	2:58 PM M
4	Examin	ier	18808 Dover Dr					erst		o Death		1	hing	
	Funeral		Social Security Number 6.5	Sex 7. Ag	ge (In yrs. lasi	t birthday)	If Under Months	1 Year	If Under	24 Hrs. 8	B. Date of Birth (Month, Day	1		place (State or Foreign intry)
а	Director		220-34-1000	1□ M 2∏F	66	Yrs.	Months	Days	Hours		eb 7,		Mary	
	and	}	Usuel Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation							10d. Inside City Limits
	Maryl	ō	MD Washing	ton	F	lager	stown							1 ☐ Yes 2 ☐ No
	n 18a	lrec	10e. Street and Number				10f. Zip	Code			1	10g. Citizen of	What Cou	
	23a c	aiD	18808 Dover Dri	ve					2174	0			USA	
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, its Madical Examinational be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Armed Forces: 1 Yes 2 If Yes, Give	?		Was Deced f Yes, spec		spanic Ori , Mexican Specify:	gin? (Sp <i>ec</i> i, Puerto Ri	fy Yes or No- ican, etc.)		ck, White	
00	tural'	ed b	3 Widowed 4 Divorced 15. Decedent's E	Year or Dates:			dent's Usua		tion			16b. Kind of B		white
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212	Hygiene. Hygiene. Ither then "	E O	12	College (1-4or	3+)	r	egist	ered	nur	se		healt!	h	
pu	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last									Maiden Surnan	ne)	
yla	2 should be fi and Mental H ie markad ot sumatic ever	၉	Carol Overton							Edna				
Maryland	d 2 st th and 7 ie n traun		19a. Informant's Name/Relationship		1		_					r, City or Town,		
Baltimore,	0 0		David M. Kennedy 20a. Method of Disposition 1 Burial 2 Cremation 3 [4 X Donation 5 Other (Speci	Removal from State	com	e of Dispo	sition (Nan natory or o	ne of		e Hage Da	erstown te	20c. Location	21740 City or T	
Baltii	permit. Peg Depertment Important: I any injury o		21. Signature of Euneral Sovice Lice Ronal d. S.		ector		Name an ate A		-		655 W.	Baltimo	ore S	Street
	Physician		23a. Part1. Enter the disease, or con shock, otheart failure. List only Immediate Cause (Final disease or condition	nplications that cause one cause on each I	d the death. ine.		er the mod		, such as		respiratory arr	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):		NEC						1 9 82.75
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Box 6	law requires that the death centificate be executed as been signed by the attending physicien and 2 should be datached for use as the burial-trainsit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pr						te of deliventh	rery Day Year
rds, P.O.	quires that t n signed by id be datad		Part II. Other significant conditions	contributing to death t	but not resulti	ng in the u	nderlying c	ause give	n in Part I.			bacco use con		the cause of death?
of Vital Records,	The law requir ate has been si page 2 should	Completed									24a. Was a autop perfor	med?//	Were autoprior to codeath?	opsy findings available ompletion of cause of
/ita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?						26. Place	of Death	Check only or			
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati		VOutpatier		700	4 140			ence 6 □Oth	_	fy)
n C	After funera	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injui	ury 28 ay Year)	8b. Time o Injury		Bc. Injury Work			ld. Describe h	ow injury occur	red	
Division	or Attandition of Att	Certification:	2 Accident investigation 3 Suicide 6 Could not lead to determined	28e. Place of In	ijury - At home tc. (Specify)	e, farm, str	M reet, factory		′es 2□		f. Location (S City or Tow	ireet and Numl n, State)	per or Rur	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner s	of examination	edge, deat n and/or in	h occurred vestigation,	at the tim in my op	e, date an inion, dea	d place, ar th occurred	d due to the o	ause(s) and made,	anner as	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	J. Mus	land	ma	,	License	111	6)		29d. Date signe) 10) (-
_			30. Name and address of person who	Cornecte	111	110	Print) Med	le d	(in	yes	Bux	-,stw.		no
	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 8 2005	32. Regist	trar's Signatur	Speed	w							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month AMES Ju 1150PM LINGG 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 14, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign XXM 2□F 84 Yrs. 214-18-6588 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9561 Ashlyn Circle 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married 1 ☐ Yes XXNo 3 Widowed 4 Divorced Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shop Foreman Manufacturing 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Felix Lingg Blanche Whitcomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia M. Lingg/Spouse 9561 Ashlyn Circle; Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State * 4 ☐ Donation S ☐ Other (Specify) Metro Crematory Inc. 7/18/05 Baltimore, MD 21. Signature Finer Service Lice 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. uchans 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CORONARY HEART BISEASE Due to (or as a consequence of) Due to (or as a consequence or). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

Physician /Medical Examiner

burial-transit

bed 1

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Box 68760,

P.0.

Records,

Division of Vital

Examiner

Be

2

Certification;

Medical

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permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

Director

Be Completed by Funeral

2

MD

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturel", or Items 23a or 28a-f show ury or other traumatic avant. It Ext. infrar. hast be notified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Completed by Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably

24a. Was an 1 ☐ Yes

RANDALLSTOWN, MARYLANDO1135

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one)

2**0**0 1 ☐ Yes

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Deat

29b. Signature and title of certifier

Date of Injury (Month, Day Year) 5 Pending investigation

and manner stated.

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Natural

2 Accident

4 Homicide

3 Suicide

29c. License number

D62912

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) JULY 15 2065

30. Name an addr-si of person who complete cause of death (Item 23a) (Type, Print)

OLD COUR NW HC 540 ROAD

31. Date filed (Month, Day, Year) 32. Registrar's Signature

JUL 1 8 2005

6 ☐ Could not be

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland		artment of				giene 1.ag. 2.00 9	5 2331	9
	Physici		1. Decedent's Name (First, Middle, Las	LEWIS					2. Date of Dea Month	Day	3. Time of De	
	/Medic		4a. Facility Name (If not institution, give			4b. City, Towr	n, or Location	of Death		4c. County o		1
	Examin	er	_	MEDICAL CET	NTFR		MOR		10		NIA	
	Funeral		5. Social Security Number - 6. Se	7. Age (In yrs. last		If Under 1 Ye	ar If Unde		B. Date of Birth (Month, Day	7 / 2 - 1	9. Birthplace (State or F Country)	oreign
	Director		218-30-6091	M 2□F 72	Yrs.	Months Day	ys Hours	Min.	Month, Day	1933	N.C.	
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation					10d. Inside City	Limite
	f sho	ō	md 1/1				_				1 Yes 2	
	289-	Director	10e. Street and Number	7 JA	412	MORE 10f. Zip Cod				10g. Citizen of Wh	, ,	
	3a or	۵	2006 /0	p/pp /2001	~		2/2/	10			1.5.A	
	72 hours after death with the Maryland natural', or Iteme 23a or 286-f show dissa Examinar must be notified at	Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	13. \	Was Decedent of Yes, specify C			ify Yes or No-		- American Indian,	
9	or Ite		1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No If Yes, Give		r Yes, specify C 1 □ Yes 2 2 1			ican, etc.)		White, etc.	
21215-0036	72 hours natural', dical Exa	d by	3 ☐ Widowed 4 Divorced	Year or Dates:		10 105 42(1	NO Specify	·•		Specify:	Black	
5	n 72 hour "natural edical Ex	Completed	15. Decedent's Ed (Specify only highest grad		6a. Deced	dent's Usual Oc kind of work do OO NOT use rel	cupation ne during mo	st of working	9	16b. Kind of Bus	iness/Industry	
12	within ene. than "	d L	Elementary/Secondary (0-12)	College (1-4or 5+)	1119.	DO NOT USB TOL) De-			Den	rond CAB	/_
	filed Hygi Sther	e C	17. Father's Name (First, Middle, Last)	7-///			18. Moth	ner's Name	(First, Middle,	Maiden Surname	ONCI CHO	,0
an	lid be lental rked c	To B	11/7/17pm	LEWZS			1	Paris	100	110		
Maryland	2 should and Mer Is marke eumatic	-	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Stre	eet and Numb	per or Rural	Route Numbe	r, City or Town, S	tate, Zip Code)	
S	7 5 7 5		Lucius .	TOHNSON SING	20	06	Bods	e a	Rax	51./3	the, nd. o	7/26
e,	es 1 and of Healt fitem 2 rother		20a. Method of Disposition		e of Dispo	sition (Name of	place)	Da			ity or Town, State	
Ē	D 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	REN	Gener	Toes	7/1	4/05	Turra	ik Md.	
Baltimore	permit. Pag Department Importent: any Injury once.		21. Signature of Funeral Service Licen	39	22	. Name and Ad	dress of Faci	lity 72	ENdor	LINE	RAL Horn	٠,
_	20E 29		Burk (10male	2	318 E.	Bu	TENO	e 5%.	- Buck	, md. 212	
			23a Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death. I one cause on each line.	Do not ent	er the mode of	dying, such a	s cardiac or	respiratory ar	rest,	Approximate Interval Betwe	en
	Pnysician		Immediate Cause (Final disease or condition	ACOTE RE	SPIR	ATORY	DIE	STRES	5 541	NOROM	Onset and Dea	
	/Medical Examiner	П	resulting in death)	Due to (or as a consequen							, , , , , ,	
В	LAGITITICI	Ļ	Sequentially list conditions,	b								
	led sslt	Examine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons⊸uen	ice off.							
	be executed sicien end burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a consequen	ice of):							
8760	ate be executed hysicien end the burial-transli	dical E		d								
687		edic		u								
ŏ	death certifics e attending ph id for use as tl	Physiclan/Me	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		75				23d. Date	of delivery	
8	0 0 0	ic a	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal de 4 Pregnant at time of death]Ectopic pregna] Other (s <i>pecify</i>				Mont	h Day Yea	ır
P.0	at the de by the	hys	9 Unknown	9□ Unknown								
Ś	es tha gned l be det	by	Part II. Other significant conditions of			nderlying cause	given in Part	1.			oute to the cause of dea	
ord	w require been sl	ted	CONGESTIVE +	PEART FAILU	RE				1 🗆 Y	es 2□No 3	Probably 4 🛣 Unk	inown
Record	a a c	Completed	CIRRHOSIS						24a. Was a	an 24b. W	ere autopsy findings ava or to completion of caus	ailable se of
= R		Con							perfor	med? de	ath? ⊒Yes 2⊠LNo	
Vital	Physicien: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	No. 201			_	e of Death	(Check only o	ne)		
of	Physi this c	2	1 Yes 2 No			I JUDON				ence 6 Other		
nc On	ding h h. After funer	ion	27. Manner of Death 1. ■ Natural 5 □ Pending	(Month, Day Year)	Bb. Time of Injury		njury at Work?		3d. Describe h	ow injury occurred	d	
<u>.si</u>	l or Attendi after death. Director: A	icat	2 Accident investigation 3 Suicide 6 Could not be		form of		I □ Yes 2 □		of Location /S	Stroot and Number	or Rural Route Numbe	
Division	of or Attendated after death	Certification;	4 Homicide determined	building, etc. (Specify)	, raini, sti	6 61, Iactory, Olli	CO .	2.	City or Tow		OI NOIRI NORE INGINDE	5
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Cartifying Ph	ysician: To the best of my knowle	dge, deat	occurred at the	e time, date a	nd place, ar	nd due to the r	ause(s) and man	ner as stated	
	Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho H	Medical	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	and/or in	vestigation, in m	ny opinion, de	ath occurre	d at the time, o	date and place, ar	d due to the cause(s)	
	To th Withir To th	M	29b. Signature and title of certifier	1		29c. Lic	ense number			29d. Date signed	(Month, Day, Year)	
			1 Clarup Ki	ila M.D.		AM	2556	996N	1185	7/12/2	005	
12	11		30. Name and address of person who	completed cause of death (Item 23	3a) (Type,							
H	. ~1		AARUP KUBA	L 2904 EU	LIDT	TST	BAL	TIMO	RE, N	10 212	24	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	е							
	Regist	rar	JUL 1 8 2	005 Mesers	1. 0	route)						

Projection Function Func			For State Registrar 1. Decedent's Name (First, Middle, La			epartment of Certificate o	Health and M f Death	Mental Hyo	Reg. 12 .005	23320
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Baltimore City 10% Free and Number 10% Expected			212-60-1836	□ M 2 💢 F	54 Yr	s. Months Day	s Hours Min.	Feb. 18	, Year) 951 Ma	aryland
13a. Informant's Name-Relationship (Type, Print) 13b. Masling Address (Street and Number or Rival Route Number. City or Town, State, Zip Code) 32 D5 Dillon Street, Baltimore, MD 21224 20a. Melhod of Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. D	iffed at	į į								10d. Inside City Limits 1 Ž¥Yes 2 ☐ No
13a. Informant's Name-Relationship (Type, Print) 13b. Masling Address (Street and Number or Rival Route Number. City or Town, State, Zip Code) 32 D5 Dillon Street, Baltimore, MD 21224 20a. Melhod of Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. Deposition 20a. D	at twing	ai Dire		d Avenue						
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19a Informant's Name-Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 Dillon Street, Baltimore, MD 21224 20a Method of Disposition 10 July 21 20a Method of Disposition 10 July 21 20a Method of Disposition 10 July 21 20a Method of Disposition 10 July 21 20a Method of Disposition 10 July 21 20a Method of Disposition 10 July 21 20a Method of Disposition 10 July 21 20a Method of Disposition 10 July 21 20a Method of Disposition 10 July 21 20a Method of Disposition 10 July 21 20a Method of Disposition 20a Method 20a Method of Disposition 20a Method of Disposition 20a Method 20a Method of Disposition 20a Method of Disposition 20a Method of Disposition 20a Method of Disposition 20a Method of Disposition 20a Method of Disposition 20a Method of Disposition 20a Method of Disposition 20a Method of Disposition 20a Method of Disposition 20a Method of Disposition 20a Method of Disposition 20a Method of Disposition 20a Method 20a Method of Disposition 20a Method of Disposition 20a Met	odkoal E		15. Decedent's E	ducation	(0	Give kind of work dor	ne during most of work	ing	16b. Kind of Busines	s/Industry
19 19 19 19 19 19 19 19	The Ma	omo	Elementary/Secondary (0-12)	College (1-4or 5					County Go	vernment
20b. Method of Disposition 20c. Location City or Town, State Vest Affince Cit		Be	Paul Loverde				Phyllis	s Mays		
Continue Continue	er traum	3		**						, Zip Code)
22. Name and Address of Facility Rend'on Funeral Home, P.A. 2818 East Baltimore Street, Baltimore, Name 2818 East Baltimore Street, Baltimore, Name 2818 East Baltimore Street, Baltimore, Name 2818 East Baltimore Street, Baltimore, Name 2818 East Baltimore Street, Baltimore, Name 2818 East Baltimore Street, Baltimore, Name 2818 East Baltimore Street, Baltimore, Name 2818 East Baltimore Street, Baltimore, Name 2818 East Baltimore Street, Baltimore, Name 2818 East Baltimore Street, Baltimore, Name 2818 East Baltimore Street, Baltimore, Name 2818 East Baltimore 2828 Date 2838 Date 2848 East Baltimore 2848 Date 2858 Date 2858 Date 2858 Date 2868 Date 2868 Date 2868 Date 2868 Date 2868 Date 2878 Date 28	ry or oth		1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of D cometery. West Ari	isposition (Name of crematory or other p INCEL CREI	hatory July	516		
23a	any nju		21 Ignature of Funeral S-rvice Live			22. Name and Add	ress of Facility Rer	ndon Fur	neral Home creet,Balt	, P.A. imore,MD2122
Due to (or as a consequence of): Consequence of consequence of	sician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	10.			or respiratory ar	rest,	Approximate Interval Between Onset and Death 18 months
Due to (or as a consequence of): Due to (or as a consequence of):	niner			W						5 years
1 Yes 2 No 3 Death 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No No	urial-transit	Exa	that initiated events	c						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonal Hypertension 24a. Was an autopsy performed? Pulmonal Hypertension 24b. Were autopsy finding prior to completion of death? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? Pulmonal Hypertension of death? 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? Pulmonal Hypertension of death? 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? Pulmonal Hypertension of death? 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 24a. Was an autopsy performed? Pulmonal Hypertension of death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury - At home, farm, street, factory, office 28b. Place of Injury - At home, farm, street, factory, office 28c. Cartifier 28d. Location (Street and Number or Rural Route No. City or Town, State) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Month) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Month) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Month) 29c. License number 29d. Date signed (Month, Day, Year, Month) 29d. Date signed (Month, Day, Year, Month) 29d. Date signed (Month, Day, Year, Month) 29d. Date signed (Month, Day, Year, Month) 29d. Date signed (Month, Day, Year, Month) 29d. Date signed (Month, Day, Year, Month) 29d. Date signed (Month) r use as the b		23b. Was decedent pregnant	23c. If yes, outcome		3∏Ectopic pregnar	nev				
Pulmonant Conditions contributing to death out not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4	ached fo	Jasici	1 ☐ Yes 2 ☐ No		time of death				Month	Day Year
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Place of Injury 28. Date of Death 28. Date of	500	ò	_			ne underlying cause	given in Part I.			
27. Manner of Death 12 Natural 2 Accident S Pending investigation S Suicide A Homicide S Pending investigation S Pending	page 2							autop	sy prior to med? death?	completion of cause of
The state of the control of the co	ecto	20	examiner?	Hospital:		(Ither			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year, MCDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	sid id	·· +	27. Manner of Death 1 ★ Natural 5 Pending	28a. Date of Injui (Month, Day	ry 28b. Tim	ne of 28c. In	jury at			recify)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	oletely fills		(Check only 2 Medical Exar	niner: On the basis of	examination and/o	leath occurred at the or investigation, in my	time, date and place, y opinion, death occurr	and due to the cred at the time, c	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	comp	Σ	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Mor	nth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	<		XAM- MEDIC	AL DOCTOR	2	RI	ES-000		JULY 14,	2005
RUPAL MARANI JOHNS HOPKINS MOSPITAL GOO NORTH WOLFESTREET BATIMORE MARYLAND 213 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year)			RUPAL MARANI JOHNS -	HOPKINS HOS	PITAL, 60	O NORTH W	JOLFE STREET	BALTIN	MORE HARYU	AND 31387

			For State Registrar	State of Mary	•		t of Hea e of De		d Mer		iene _{eg. N} 20 (0.5	23321
AIF	Physici /Medic		Decedent's Name (First, Middle, Last BETTY JEA)							Date of Deal Month JULY	th) 0°5°	3. Time of Death 10:20P M
	Examin	er	4a. Facility Name (If not institution, give HARBOR HOSPI' 5. Social Security Number 6. Se	PAL	yrs. last birthday)		LTIM		CITY		4c. County	N/A	
	Funeral Director				58 Yrs.	Months			Vlin.	Date of Birth (Month, Day, 02/01	/1947	Count	ace (State or Foreign ry) H CAROLIN
	e Maryland ta-f ahow	ctor	10a. State 10b. County N/A	10	c. City, Town or Lo		CITY					10	od. Inside City Limits 1 ▼Yes 2 □ No
	with the	Dire	10e. Street and Number	2012		10f. Zip		4.0		1	0g. Citizen of		try?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f ahow or other traumatic event, the Medical Eran are must be notified at	by Funeral Director	1638 RALWORTH 11. Marital Status 1 Never Married 2 Married 3 Widowed	12. Was Decedent Ever Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates:		Was Deced If Yes, spec			? (Specify uerto Rica	Yes or No- an, etc.)		ce - America ck, White, e	
21215-0036	within 72 ho iene. • than "natur the Medical I	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of wor DO NOT us	I Occupation k done durir e retired)	ng most of	working		16b. Kind of B		COMPANY
Maryland 2	uld be filed Mental Hygir irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last)	1 YEAR ATES	1 -			. Mother's	Name (Fi		Maiden Suman GROVE	ne)	
	1 and 2 should I Health and Ment em 27 is marker ither traumatic		19a. Informant's Name/Relationship (T)	/ DAUGHTE	ER 38 I	BROOK	S TE		E, 0	SLEN I	; City or Town, BURNIE		^{Code)} 21060
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe		20a. Method of Disposition 1 XBurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	Ob. Place of Dispo cemetery, crea LOUDON	matory or of	ther place)	. 7	Date / 18/		20c. Location - BALTIM		
Ball	permit. Pa Departmer Important: any injury once.		21. Signature Puneral Service Licens	in X			d Address of LIBE				UNERAL AVE. B		E 21207 MORE, MD
	Physician		23a. 7411. Enter the disease, or comp stock, of heart fature. List only o Immediate Cause (Pinal disease or condition	lications that caused the ne cause on each line.	death Do not ent		of dying, s		diac or re	spiratory arre			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co		<i>/ / /</i>							
V	executed in and riat-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co						_			
8760,	ate be executed thysician and the burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):								
.O. Box 6	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pre						te of deliver	y Day Year
Ω,	luires that the signed by th ild be detache	by	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying ca	iuse given ir	n Part I.		23e. Did tob			cause of death?
Division of Vital Records,	The law requires ate has been sign page 2 should be	Completed								24a. Was a autops perform	y ned?	prior to com death?	sy findings available pletion of cause of
Vita	Physician: The tribic certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital:			Othor			heck only on			
ion of	Attending Phys r death. sctor: After this by the funeral di	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	28b. Time o ar) Injury		Bc. Injury at Work?	4 □ Nursin			ow injury occur)
Divis	P fee	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S		reet, factory,	, office			Location (St. City or Town		er or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier Check only one) Certifying Phy	sicien: To the best of m iner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred a vestigation,	at the time, d	date and pl	lace, and occurred a	due to the ca	ause(s) and ma ate and place,	anner as sta and due to	ited. the cause(s)
)	To th within To th	Ž	29b. Signature and title of contifier	17		29c.	License nu	mber 085	7	25	9d. Date signe	d (Month, D	
	15		30. Name and address of person who	Risebera	MD	Print)	01	5+, 1	Paul	PI.	Bultim	ore	21202
	Sta Registr		31. Date filed (Month=Day, Year) JUL 1 6	32. Redstrar's	Signature	Joseph .	,		-				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13^{Day} **Physician** $J_{\mathbf{u}}^{\text{Month}}\mathbf{y}$ 2005 11:30A M Mason, Sr. Melvin James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 4409 East west Hwy Crescent City Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept. 16, 1927 6. Sex 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**x** M 2□F 578-30-2222 Wash. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exercit et mart be retilled at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Prince George's Forestville X MYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20747 7003 Nimitz Dr. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No If Yes, Give 7, 5, 7, 6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Year or Dates: 45-46 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mailer Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Thomas Mason Lucy Madgeline Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7003 Nimitz Dr. Forestville, Md. 20747 Marguerite R. Mason/ wife 20a. Method of Disposition

X ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Resurrection Cemetery 7/16/05 Clinton, Md. ^¹ 4 □ Donation 5 □ Other (Specify) 21. Sign were of Funeral Serv 22. Name and Address of Facility Lee Funeral Home 6633 Old Alexander Ferry Rd. Clinton, Md. 400153 23a Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician week disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 1 Yes ŽONo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page Ž(XNo 1 🗌 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deensbury Rd Hyghtsville MDZOB 4203 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 8 2005 Registrar

05-4682 B.K.S UNKNOWN 05-4682

Physic /Medi Examir		For Unpend Ite Registrar 1. Decedent's Name (First, Middle					Deanr	1		03	23323
		Elliott		F	renti	ce		2. Date of De Month	Day 11. 20	Year O5	3. Time of Death 4:45 P M
Lxamiii		4a. Facility Name (If not institution 1653 EAST COLI					T Location of Dear		4c. Count	ny of Death	1 7.47 F
Funeral Director		5. Social Security Number 162-56-0170	6. Sex 7. 1 X M 2 ☐ F	. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ly, Year)	9. Birthi Coul	place (State or Foreign ntry)
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artmer artmer ortant injury	1	4 ☐ Donation 5 ☐ Other (S) 21. Signature of Funeral Service	1	, Ki	_	m. Pk. Name and Addre		6-05	Randal		
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46		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that can	sed the death.	Do not ente	r the mode of dyir	g, such as cardia	c or respiratory ar	rrest,		Approximate Interval Between
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K	Physicia /Medid		Evgene Pe	rodine				07	09 200	72 (20 by
N. Control	Examin	er	4a. Facility Name (If not institution, give	street and number)	Hund	4b. City, Town, o	r Location of Death Balti		4c. County of De	ath
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altimore,	Page ment o ant: If ury or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 1 □ Donation 5 ☑ Other (Specify)	20b. Postate in state	lace of Dispos ametery, crem	sition (Name of eatory or other place	ce)	Date	20c. Location - City of	or Town, Stale
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7	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or compleshack, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	acations that caused the dear actions that caused the dear actions of the caused a	Do not ente		MD 2120 ng, such as cardiac	or respiratory ar		Approximate Interval Between Opset and Death
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	To the Hospitel or Attending Ph within 24 hours after death, To the Funetel Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death	occurred at the tir restigation, in my o	ne, date and place	, and due to the	cause(s) and manner	as stated. ue to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier) RA		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
			30. Name and address of person who c	Propleted cause of death (Item	23a) (Type, I	Print) Hoc /	o la d	RALL	MONO	, , , ,
•	Sta Regist		31. Date filed (Month, Daf, Year)	32. Registrar's Signa	ture	2	1		, , , , ,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 19a per fh 8845 7-16-05 yt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** HATTIE ORLEE PEAY 2005 JULY<u>13</u> 9:46 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER FOR TOWSON

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) HOSPICE BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2₽F Months 062-14-6292 88 Director 10/14/1916 SOUTH CAROLINA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examinar wast be notified at XXYes 2 No Directo MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 239 5842 WYNDHAM CIRCLE #105 21044 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: BLACK 3√2 Widowed 4 □ Divorced 'naturel', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOMEMAKER SELF-EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental h DENNIS JANE LENNIX MARY LENNIX 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 19a. Informant's Name/Relationship (Type, Print) JAMES PEAY JR / SON 10380 SWIFT STREAM PL #104, COLUMBIA, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō <u>-</u> 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
14 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department of Importent: If any injury or once. GREENWOOD UNION CEM 7-19-03 RYE, NEW YORK wheral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Stoke weeks resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4□Pregnant at time of death 5 Otner (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 20 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 the ther (Specify) 1 ☐ Yes 2 ☑No Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Hospitel or Attending Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

7

State

29b Signature and title of certifier

ARON 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Som

auris

6601 N. Charles

29c. License number

5 8303

St Tonson, mo zizay

29d. Date signed (Month, Day, Year)

) JUY 132005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 015 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner saltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 M 2 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumetic event, the Medical Examinant mat be notified at Baltimore 1 Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA or Items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No !! Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) i. Pages 1 and 2 should be filed within timent of Health and Mental Hyglene. Tant: If Item 27 is marked other than "ijury or other traumetic event, Ite Ma Elementary/Secondary (0-12) College (1-4or 5+) DRY Cleaner and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Velmer Hill 2 unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Mue Brickhouse - Sister 918 N. Franklintown Rd. Balto. MD 21216 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Methed of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. Garrison Forest V.A. 4 Donation Other (Specify) Owings mills 21. Signature the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest part failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** tspiration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-transit piratori ue to (r as a consequence of Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Whiknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No , page 2 s 2 No Division of Vital 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check on one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) eted çause of death (Item 23a) (Type, Print che va

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 8 2005

			For State Registrar	State of Maryland		artment rtificate			ind M	ental Hy		e 200	5	233	27
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	/Medic Examin		4a. Fecility Name (If not institution, give since Carriage Hill	treet and number)		4b. City, T Be	own, or t		f Death		1	c. County o		y	
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	r 28a	Director	10e. Street and Number	(L	CLIOTEIG	10f. Zip Code			10g. Citizen of What	t Country?					
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	/Medic	al	Elsie G. Russin				45 Ch T	-1	July		2005	6:50 PM
7	Examin	er	4a. Facility Name (If not institution, give st Ivy Hall Nursing	· ·			4b. City, Town, o Balti		เท	40	County of Dea Baltim	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birt	thday)	If Under 1 Year	If Under 24 Hr	S. 8. Date of E	Birth Day, Year,		rthplace (State or Foreign Country)
	Director		214-12-0030	M 2 7 F	82	Yrs.	Months Days	Hours Mir	Feb 4	192	3 Ma	iryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Lo	cation					10d. Inside City Limits
	Mary 8-1 sh	tor	MD Baltimor	re	1	Bal	timore					1 ☐ Yes 2√7 No
	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What C	Country?
	s 238		16 Compass Road	O Man Danadant F	ives in 11.0	10.1	W D d d-1	21220	0	1-	USA	
	fter de	Funeral	11. Marital Status 12 Married 12 Married 13	 Was Decedent E Armed Forces? 1 ☐ Yes 2 X N 		13. V	Vas Decedent of H i Yes, specify Cuba	an, Mexican, Pue	rto Rican, etc.)	NO-	14. Race - Am Black, Wh	
036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or litems 23a or 28a-f show aumatic event, if a Medical Exertical national tencilities.	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1	∏Yes 2√∏No	Specify:			Specify: W]	nite
5	"natu	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a.	(Give .	lent's Usual Occup kind of work done OO NOT use retired	during most of w	orking	16b. H	(ind of Busines	s/Industry
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br	ould be filed with	Be C	17. Father's Name (First, Middle, Last)				warerege	18. Mother's Na	ımə (First, Midd	le, Maidei		<i>5</i> u
<u>ylar</u>	Menta Menta arked atic e	ToE	Frank Christerfe	r Spurry					Mary E			
Maryland 21215-0036	d 2 sho th and th sin traum		19a. Informant's Name/Relationship (<i>Typ</i> Patricia Matheny/c				g Address (Street E. Hombe					. ,
ē,	s 1 an f Heal item 3		20a. Method of Disposition		20b. Place of	Dispos	sition (Name of natory or other place		Date	_	ocation - City o	
altimore,	Page Iment c tant: If jury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☑ Donation 5 ☐ Other (Specify)									
Ball	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service License Ronald S W	ade, Dire	W.	S B	Name and Addre tate Ana altimore	ss of Facility Lomy Boa , MD 21	rd 655 1 201	W. Ba	altimore	e Street
			23a. Part1. Boter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each lin	the death. Do n	not ente	er the mode of dyin	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
) 1	Physician /Medical		Immediate Causè (Final disease or condition resulting in death)	- Duada (araa a	OM	1						
	Examiner			Duano (og as a	consequence of	oi):	MAS	T				
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence o	of):	Pa 11.	2. A	1			
	ate be executed nysician and he burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of	of):	W WY	11				
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	rtificat ng phy as the		ISSECUAL S									
Вох	eath certifica attending pl	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of	2 Fetal death		Ectopic pregnancy	/			23d. Date of de Month	elivery Day Year
P. 0	that the de led by the a detached t	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	51_	Other (specify)					
ر.	res that igned b be deta	by Pł	Part II. Other significant conditions cont	ributing to death bu	ıt not resulting in	n the ur	nderlying cause giv	en in Part I.	23e. Dio	tobacco	use contribute	to the cause of death?
ord	w require been sig should b								1	Yes 2	□ No 3 □ F	Probably 4 (mknown
ec	he law r s has be ge 2 sh	Completed							24a. Wa	topsy	24b. Were a	autopsy findings available completion of cause of
Vital Records,	r: The								1 ☐ Yes		death? 1 ☐ Ye	s 2 No
Z.	s certification	o Be	25. Was case referred to medical examiner? 1 \sum Yes 25 \sum No	ospital:	nt 2 ER/Out	toatien	t 3 DOA Oth	05 4	eath (Check onl) Home 5 Re		6 ∏Other (So	acity)
l of	nding Physician: The la uh. :: After this certificate has e funeral director, page 2	H .	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. T	Time of	28c. Injur Wor		28d. Describ		~	outy)
sior	r Attendin er death. rector: Af by the fur	catlo	1 ★ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(0.000)		.,,		Yes 2 □ No				
Division of	l or Atten after deatl Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	iry - At home, fai c. (Specify)	rm, stre	eet, factory, office		28f. Location City or 7	_(Street a own, Stat	nd Number or F e)	Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for tise as the		29a. Certifier (Check only 2 Medical Examin	er: On the bases of	examination and	, death	occurred at the tir	me, date and place	e, and due to the	e cause(s	s) and manner and place, and du	as stated.
	o the l	Medical	one) 29b. Signature and title of certifier	and manger sta	ted.		29c. Licens				ate signed (Mor	
	- s + ŏ		Sanu-	di	110	1	6	380	33	-	7/91	105
			30. Name and address of person who cor	7/1	eath (Item 23a) (Tyge,	Pright)	Mor 1	To A	1110	u Li	2 21216
			31. Date filed (Month, Day, Year)	JG/ S. Registra	ar's Signature	1	1004/	166	00	mi	v Fl	1 21319
	Sta Registi		JUL 1 8 2005	Beer	JE A	004	ري	/				

	an	1 Decedent's Name (First, Middle, L	Anniebell	Smith	-			Day Year .5 2005	3. Time of Death				
Medic amin		4a. Facility Name (If not institution, g		N FT	4b. City, Town, or Lo			4c. County of Dea	th				
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eral ctor		5. Social Security Number 6. 217–24–2809 Usual Residence of Decedent	Sex 7. Age (In 1	yrs. last birthday) Yrs.			te of Birth lonth, Day, Ye 12–30–	ear) Co	thplace (State or Fore ountry) Md.				
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Tipod Tipod	ctor	Md.	NA	Baltim	ore				1 X Yes 2 □ I				
000	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?				
arat		4916 St. Georg			21212			USA					
LIBIT	Funerai	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ever	in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Specify Y Mexican, Puerto Rican,	es or No- etc.)	14. Race - Ame Black, Whit					
Medical Exertinet mast be notified at	Þ	3 Widowed 4 □ Divorced	I ☐ Yes 2√ No If Yes, Give Year or Dates:		1☐ Yes 2☐XNo S	Specify:		Specify: B	lack				
Scal	Completed	15. Decedent's (Specify only highest of	Education	16a. Dece	dent's Usual Occupation	n na most of working	165	o. Kind of Business	/Industry				
Me.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done duril DO NOT use retired) Chef	ng most of working		Roof Top-I	Hocht Co				
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other treumatic	၉	19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street and		e Number Ci						
r treu		Harry Smith	Son		Brigade	ırt, Owings			21117				
othe		20a. Method of Disposition	20	b. Place of Dispo	osition (Name of matory or other place)	Date		Location - City or					
iry or		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Themoval itolii State		Mem. Park	7-23-05		Arbutus M	Md.				
any injury or c		21. Signature of Funeral Service Lic	ensee	22	2. Name and Address o	f Facility E	altimo	re, Md.	21202				
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		23a. Part 1. Enter the disease, or complications that caused the Section Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. Lis only one cause on each line. Immediate Cause (Final Onset a.											
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY 12, 2005 **Physician** 2:30 AM Ε. SVINGOS HELEN /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner MANOR CARE-ROSSVILLE ROSEDALE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year JULY 9, 1 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2□F Yrs. Director 232-36-5241 78 WEST VIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Int: If Item 27 is marked other than "natural; or itema 23a or 28a-f ehow 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f ehow traumatic event, the Mudical Examinar must be notified at 1**Y** Yes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8035 E. BALTIMORE STREET UNITED STATES 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify ģ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) SECRETARY BALTIMORE CITY POLICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN EVANGELINOS MARY SESTINA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES J. SVINGOS-HUSBAND 8035 E. BALTIMORE ST. BALTIMORE, MARYLAND 21224 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ö permit. Page Department o important: If OAK LAWN CEMETERY 7/14/05 BALTIMORE, MARYLAND ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signatura of Funeral Service Licensee CHARLES S. ZEILER & SON. INC. 22. Name and Address of Facility any it 3a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear failure. List only one cause on each line.

H465 - 14 6224 EASTERN AVE. BALTIMORE MARYLAND 21224 Approximate Interval Between Onset and Death Immediate Sause Final disease or condition resulting in death) HYPOXIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. detached Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed SC VD 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 2 1 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner Hospital: 1 Inpatient Other: 4 Arriving Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 740 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred Certification: After 1 Natoral
2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide e Funeral C Medicai 29a. Certifier 12 critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 055306 Delle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 PHILADERPHA RD SCITE 200, BALTO. MD 21237 DENNIS HI BDIE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1 8 2005

ORIGINAL

			Please Type or Print in Black			-								
			_ FUI	epartment of Health and Me										
			1 - State Registrar AMEND ITEM #5 PER FH C846 8/ 1. Decedent's Name (First, Middle, Last)	02/05 JH	Reg. No. 1	3. Time of Death								
	Physicia /Medic		Fay G. Simmons		July	13 2005 2:12 P.M								
	Examin	er	4a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Cen	4b. City, Town, or Location of Death Glen Burnie	4	App o Amenda 1								
	Comment		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		Date of Birth	Anne Arundel 9. Birthplace (State or Foreign								
i e	Funeral Director		1 M 2 F 89 Y	Months Days Hours Min.	(Month Day Yes	915 Pennsylvania								
	ylend		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits								
	a-fs)	ctor	Maryland N/A Balt	imore		1 XYes 2 No								
	h with the	Funeral Director	10e. Street and Number 104 W. Jeffrey Street	10f. Zip Code 21225	10g. (Citizen of What Country? U.S.								
	deatl	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specifical II Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No-	14. Race - American Indian, Black, White, etc.								
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Evantinal must be mullified at	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No Specify:	an, 610.)	Specify: White								
5-0	72 h	etec	15. Decedent's Education 16a. I (Specify only highest grade completed) (ecedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired)	16b.	Kind of Business/Industry								
121	within ane. than	Completed		nchine Operator		Koppers								
	Hygid Hygid Sther	e Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	First, Middle, Maid									
an	fental rked c	To Be	George Decker	Ethe1	Rhome									
Maryland	and N ls ma		T 1 TT 0:	Mailing Address (Street and Number or Rural F	Route Number, City	or Town, State, Zip Code)								
	and lealth m 27 her tr					laryland 21144								
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is sny injury or other tra gnce.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State											
Itin	artmer artmer priant injury		* 4 □ Donation 5 □ Other (Specify) Cedar 21. Signature : Funeral Service Licensee	Hill Cemetery 7/16/2 22. Name and Address of Facility Gon	005 Ba	ltimore, Maryland								
8	permi Depar Impo eny ir		Honge M Znamiouski	4001 Ritchie Highway										
1-5(0)			23a. Part1. Enter the disease, or conditions that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between								
	Physician		Immediate Cause (Final disease or condition	Mys cardial Infa	retion	Onset and Death								
	/Medical Examiner		resulting in death) Due to (or as a consequence of):										
-	\$ a	-	Sequentially list conditions, if any, leading to immediate b.											
$\sqrt{}$	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
60,	be executed icien and burial-transit			C. Due to (or as a consequence of):										
6876	ate be hysici ihe bu	lical	d											
39 ×	leath certificate b rattending physic I for use as the b	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy											
Box	death o	clan	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year								
P.0.	0 0 2	hysi	1 Yes 2 KNo 9 Unknown 9 Unknown											
Records, P	requires thet the deatt een signed by the atte nould be detached for	Completed by Physician/Medic	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.		o use contribute to the cause of death? 2 \[\sum \text{No} \] 3 \[\sum \text{Probably} \] 4 \[\sum \text{Prunknown} \]								
00	~ Q to	lete			24a. Was an	24b. Were autopsy findings available								
Re	0 4 0	шо			autopsy performed: 1 ☐ Yes 2 🔯									
Vital	ystcian: The is certificate director, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death (0										
of V	S S	2	1 ☐ Yes 2 StNo Hospital: 1 ☐ Inpatient 2 🔀 ER/Outp			6 ☐Other (Specify)								
ou c	Jing F	lon	27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation 2 ☐ Accident investigation		d. Describe how in	jury occurred								
Division of	Attending r death.	Certification:	3 Suicide 6 Could not be			and Number or Rural Route Number,								
Ö	s after of Dire	Cert	4 Homicide determined building, etc. (Specify)		City or Town, St	ate)								
	To the Hospital or Attending Phwitin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and or investigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as stated, and place, and due to the cause(s)								
	To th To th Comp	Me	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)								
			Modelayra	D-40251	5	my 13, 2003								
	12		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) 325 Hospital	Drive	Suite 208								
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ade										
			TO FOOD MENTERS											

			Please	Type or Prin					•		Legible.	
		1 - State		State of Ma	arylan		artment of <i>tificate of</i>	Health and N Death	lental Hy	ygiene Reg. Ng	005	22221
		Registrar 1. Decedent's Nan	ne (First, Middle, Las	t)		067	incate of	Death	2. Date of D		000	3. Time of Death
Physici		HORTEN:	SE				SELDI	N	Month JULY	Day	Year 2005	
/Medi Examir			(If not institution, give	street and number)				or Location of Death	JON	-	County of Deat	
		Dinai	Hospital	7 0000				pore City				N/A
Funeral Director		5. Sociat Security		ex 7.Ag □M 2√7F 7.Ag	e (In yrs. i 95	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth Y Q O Q	9. Birtl	nplace (State or Foreign untry) MD
		Usuat Residence							10/0//	1303		TID
arylan ehow	_	10a. State	10b. County			y, Town or Lo	cation					10d. Inside City Limits
ith the Marylar or 28a-f ehow	Director	MD 10e. Street and Nu	BALTIMORE		BAL	TIMORE	1.27 71 70 1					1 ☐ Yes 2 X No
with sa or	Dir		COTTS LEVE	I POAD			10f. Zip Code 21208			U.S.	zen of What Co	untry?
death ma 23	Funeral	11. Marital Status	COTTS LLVL	12. Was Decedent	Ever in U.	S. 13.1		Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or N		4. Race - Ame	
os 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 Is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, its Medical Examerational be incitified at	by		rried 2 🛣 Married 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 [A]! If Yes, Give Year or Dates:	No		fYes, specify Cul		Rican, etc.)		Black, White Specify: W	a, etc. HI T E
72 h	etec	(Spe	15. Decedent's Ed	ucation de completed)		(Give	lent's Usual Occu kind of work done	during most of work	ring	16b. Kin	d of Business/l	ndustry
within ene. than	Completed	Elementary/Sec	ondary (0-12)	Cotlege (1-4or 5	5+)		OO NOT use retire MAKER	ed)		OMV	N HOME	
filed Hygir Sther	ပိ	17. Father's Name	(First, Middle, Last)	·		HOME	TAILL	18. Mother's Nam	e (First, Middle			
uld be dental rked ric ev	To Be	JULIUS				HAMB	JRGER	SOPHIE			ROTHC	HILD
2 short and h			Name/Relationship (7					t and Number or Rur				
JUDIE BACH / DAUGHTER 3736 ASHLEY WAY - OWINGS MILLS, M												
Pages 1 nent of H int: If Ite	20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) / BETH TFILOH CONG. 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH TFILOH CONG. 07/14/2005 WOODLAWN,											
그 된 원 중 .		111	5 Other (Specify	1_//	DL			ess of Facility SOI				
permi Depa Impo any is		MALL	1/me / 1	11100				TERSTOWN				
		23a. Part1. Enter	the disease, or comp art failure. List only of	plications that caused	the death	i. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause disease or conditi	(Final	, Seosis	10.							Onset and Death
/Medical Examiner		resulting in death)		Due to (or as	a consequ	uence of):						Saugs
LAUTHING	Je.	Sequentially list of if any, leading to it	onditions,	bDue to (or as	a consequ	ience of):						
uted f Insit	Examiner	Cause (Disease o	lerlying or injury		a consequ	derice on.						
be executed sician and burial-translt	Exa	that initiated event resulting in death)	Last	Due to (or as	a consequ	uence of):						
ate be hysicia he bu	lcai			d								
feath certificate b attending physic	Physician/Medical	IF FEMALE:		020 16.000 0.00000	-4					- 1		
attender of for us	cian	23b. Was deceded in the past 12	2 moeths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pregnand Other (specify)	су		2	3d. Date of deli- Month	very Day Year
by the tached	hysi	1 Tes 2		9□ Unknown		Jan 5_	Culei (specify)					
The law requires that the death certificate the has been signed by the attending phys age 2 should be detached for use as the	b	Part II. Other sign	ificent conditions of		ut not resu	ulting in the u	nderlying cause gi	ven in Part I.		tobacco us	/	the cause of death?
law re	piet	Hyperter	nsiou						24a. Wa		24b. Were aut	opsy findings available
	Completed	Demen	Ha			-				opsy formed? 2 No	death?	ompletion of cause of
yalclan: Th is certificate director, pag	Be	25. Was case refe examiner?		Manaitali d				26. Place of Deat				
this aldi	T.	1 Yes 2 2	SINO	Hospital: 1 Impatie	-	ER/Outpatien 28b. Time of	1 JUDON	her: 4 \sum Nursing Ho	me 5 Res 28d. Describe			ity)
nding th. : Afte	tion	1 ☑Natural 2 ☐ Accident	5 Pending investigation	(Month, Da)	Year)	Injury	28c. Inju Wo M 1	rk?]Yes 2□No	Zou. Describe	THOW INJURY	Occarred	
Atter	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Ptace of tnje building, etc	ury - At ho	me, farm, str	eet, factory, office	-			Number or Ru	ral Route Number,
rs after safter sal Dir	Cert	4 Nonnede		building, etc	:. (Зресну	') 			City or 10	own, State)		
To the Hoapital or Attending Physician: within 24 hours after death within 24 hours after death To the Funeral Director. After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only опе)	1 Certifying Phy 2 ☐ Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examinat	wledge, death tion and/or inv	occurred at the trestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time	cause(s) a , date and	and manner as place, and due	stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and	d title of certifier				29c. Licen	se number		29d. Date	signed (Month	, Day, Year)
di		Sain	Pin MO				RES	-000		7/1	1/2005	
3		30. Name and add	lress of person who o		_		Print)	odimore,				
		51. Date filed (Moi	nth. Day. Year)	2401 W 32. Belgistra				whomore,	MO 8	21215) ,	
Sta Registi		[1801	JUL 182		Sur d	& A	mile					

Directo

	•	For State	1 10000	State of i	Marylan		artment o			ind Me			2005		3335
		1. Decedent's Name	e (First, Middle, La	st)			rimouro				2. Date of De	ath		,	Time of Death
Physicia		ER	RNEST	M		S	TOLBER	G			JULY 1	3, ^{Da}	005 Yes	1	2:20 A M
/Medic Examin		4a. Fecility Name (/	f not institution, giv	e street and numb	er)		4b. City, To		Location of				County of De		
		4730 ATR	IUM COUR	T APT. #4	74			0	WINGS	MILL	.S			BAL	TIMORE
Funeral Director		5. Social Security N 216-09	1-9160 6. S	Sex 100 M 2□F 7.	Age (In yrs. 91	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	3. Date of Bit (Month, Da 08/07	1913 1913	9. 6	irthplece Country)	(State or Foreign
1880		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	ty, Town or Lo	ncation							10d	Inside City Limits
-f sho	tor	MD	BALTI	MORE		WINGS I									1 □ Yes 2 火 □ No
or 28.	Director	10e. Street and Nur	mber				10f. Zip C	ode				10g. Cit	izen of What	Country?	
23a c	aio	4730 ATF	RIUM COUR	T APT. #	474		21	117					U.S	.Α.	
Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Evolution must be notified at once.	by Funerai	11. Marital Status 1 □ Never Marr 3 🛣 Widowed	ied 2 Married	12. Was Decede Armed Force 1 M Yes 2 If Yes, Give Year or Date	as? □ No		Was Deceder If Yes, specify 1 ☐ Yes 2	Cubar	spanic Orig n, Mexican, Specify:	gin? (Spec , Puerto R	ify Yes or No ican, etc.)	0-	14. Race - Al Black, W Specify:		
natur	eted	(Spec	15. Decedent's E			(Give	dent's Usual (done d	uring most	of working	7	16b. K	ind of Busine	ss/Indust	ry
rgiene. er than "	Completed	Elementary/Seco	ondary (0-12)	College (1-4	or 5+)		ANICAL			R		E	NGINEE	RING	
Mental Hy arked oth atic event	To Be	17. Father's Name EDWARD				ST0	LBERG		MAR		First, Middle	, Maiden		FOL BE	ERG
and ls ma sumi			ame/Relationship		Б		ng Address (S								
feaith m 27 her tu			ADELMAN ,	/ DAUGHTE			SUUTH osition (Name		DIANA	AVE.			CHICAL ocation - City		L 60616
nt of the rest of the rest of the rest			Cremation 3	Removal from Sta	ato C	cemetery, cre	matory or other	er place			2005		TIMORE		State
artme ortan injury		21. Signature of Fu	5 Other (Speci		рил		2. Name and		1					-	
Depa Impo any i		Solo	ろろ		>		O REIS								
nysician /Medical xaminer		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List only (Final on	w	h line.	tic 1	Prost	,				arrest,		Int	proximate erval Between set and Death
h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	cat Examiner	Sequentially list or if any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death)	erlying r injury s	c	as a conseq										
phy:				0											
y the attending	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	months?		h 2 ⊡Feta ntattime of d	al déath 3[⊒Ectopic preg ⊒ Other <i>(spec</i>						23d. Date of Month	delivery Day	y Year
signed b	by	Part II. Other signi	ficent conditions	contributing to dea	th but not res	sulting in the u	underlying cau	se give	n in Part I.			tobacco		to the c	ause of death?
ate has beer page 2 shou	Completed								24a. Wa. auto perf		prior	to comple	findings available ation of cause of		
ertific ector,	Be (25. Was case refe examiner?	rred to medical					T		of Death	(Check only	one)			
this c	1 o	1 ☐ Yes 2 ₽	No.	Hospital: 1 🗆 Inp		ER/Outpatie		Othe	4 🗆 1901				6 ☐Other (S	pecify)	
eath. or: After the funera	Certification;	27. Manner of Dea 1 Natural 2 Accident	5 Pending investigation	on	Injury Day Year)	28b. Time of Injury	of 280	Work	rat (? Yes 2 □ N		3d. Describe	how inju	ry occurred		
al Direct	Certific	3 Suicide 4 Homicide	6 Could not determined	289. Place 0	f Injury - At h p, etc. <i>(Speci</i> l		treet, factory, o	office		21	Bf. Location City or To	(Street ar own, State	nd Number or e)	Rural Ro	oute Number,
within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☐ Medicel Exa	hysician: To the b miner: On the bas and manne	is of examina	owledge, dea ation and/or in	th occurred at nvestigation, in	the tim	ne, date and pinion, deat	d place, au th occurre	nd due to the	cause(s , date an	and manner d place, and d	as state	d. e cause(s)
withii To th	×	29b. Signature and		A 4			29c.	License	number				ate signed (Me		
4		► Ka	ren of	Balrit,	M.D.		DA	005	586	ديم 🗲		Jul	\$ 13,	200	5
1				completed cause				5	vite	200	Reis	+c (5.	DWD	MI	21131

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 8 2005

Hordes

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 0 0 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death JUI Y 2005 PHYLLIS SALGANIK 10:06 p ^M 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2NF Months Days 218-26-3915 77 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 □ No PALM BEACH BOCA RATON 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20320 FAIRWAY OAKS DRIVE APT. 344 33434 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY WHOLESALE ELECTRONIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GEORGE ROSEN STELLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GORDON SALGANIK / HUSBAND 20320 FAIRWAY OAKS DRIVE BOCA RATON, FL. 33434 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CHIZUK AMUNO CONG. 07/14/2005 BALTIMORE, MD 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 21. Signature Juneral Service Acenses B900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): menters concu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disasser injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 210NO 2□ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence ther (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 🕽 🖎 o 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

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d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other then *n

permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n eny injury or other treum once.

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2000

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Hospitel or Attending

within 24 hours a To the Funerel D

Director

Funeral

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Completed

Be

Examiner after death

Physiclan/Medical Be Completed Certification: To

Medical

State

Registrar

IF FEMALE:

29a. Certifier

(Check only one)

Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

nevles It

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Towson us

29b. Signature and title of certifier

29d. Date signed (Month, Dav. Year) 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles un 6/201 N ARRON

31. Date filed (Month, Day, Year) JUL 1 8 2005

cn	, , ,	•	1 - State Unpend Item	State of Ma 23a,27,28a	rylan f pe	d/Depa er me G	nment of 845 7–21 inicate of		Mental Hy	giene Reg. No.20	105	233	37
R &	Physici		Decedent's Name (First, Middle, La						2. Date of Dea Month July		Year	3. Time of 8:53	f Death
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		1	4b. City, Town, o	or Location of Dea			ity of Death	0.55	-
الله مد			East of Nebel Street	South of Ra	moln	h Road	Rocky	ille If Under 24 Hrs		Mont	gomery	7	
8169	Funeral Director		334-00-8403	Sex 7. Age	32	ast birthday) _ Yrs.	Months Days	If Under 24 Hrs Hours Min	8. Date of Birt (Month, Day Dec. 23	, Year) 1972	Coun	lace (State on try) ningto	_
0	and iand		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation				1	0d. Inside C	ity Limits
	Manyian I show	to	Maryland Montgom	erv		Pot	omac						2 ½ No
	or 288	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Coun	itry?	
	23a c	la l	10827 Deborah Dr	ive			208	554		Unit	ed Sta	ites	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itema 23a or 28a-f show this tre Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		11	/as Decedent of H Yes, specify Cub ☐ Yes 2X No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	В	aca - America lack, White, e hify: Whi	etc.	
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121	d within 72 ho piene. r then "natur It e Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)			during most of wo d)	,,,,,,,	A	_1		
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an	B la b	o Be	Bruce Vale Stade						ol Linda		ine)		
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	12 = Z		Bruce V. Stade1/F	ather					Potomac,				
Je,	of Health Itam 27	1	20a. Method of Disposition		20b. P	lace of Dispos	ition (Name of atory or other pla	cal	Date	20c. Location			
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Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service Lice	1500					Funeral	Home /	Bethes	da-Çh	evy
ш	205 2 9		23a. Part1. Enter the disease, or com		10019	755	/ WISCOIL	sin Ave.,	_betnesd	a, MD 2	20814-	3501 ⁿ	2.
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	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical (29a. Certifier 1 Cartifying Ph (Check only one) 2 Medical Example	28e. Place of Inju building, etc Scene sysician: To the best of ninar: On the basis of and manner stat	Ozaminat	wiedge, death ion and/or inve	occurred at the tirestigation, in my o	me, date and place pinion, death occ	Kockvil e, and due to the d urred at the time, d	eause(s) and relate and place	nanner as sta , and due to	ated. the cause(s	s)
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	10)		30. Name and address of person who	completed cause of de	Tanh (Item	23a) (Type, P	rint) 111 Pe	enn Stree	et Balti				201
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Regara	r's Signat	ture 5.	Soule						

Albert Roslyn Stevenson Jr.
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. TET. 05-03742 UNKNOWN State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Albert Roslyn Stevenson Jr 2005 /Medical May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1116 West Saratoga Street
5. Social Security Numberunk 6. Sex 7. / Raltimore
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 13, 1952 Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F Yrs Director Usual Residence of Decedent with the Maryland 10a. State unk 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show 7 is marked other then "neturel", or items 23e or 28e-f show treumatic event, the Medical Ever direct count be nothing at unk unk ¹□Yes 2□No Direct 10e. Street and Number unk 10f. Zip Code unk 10g. Citizen of What Country? USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "neturel", or Items 23. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No un]
If Yes, Give
Year or Dates: unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: Completed by Specify: black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk al Hygiene, Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta 111 Penn Street Baltimore, MD 21201 19a. Informant's Name/Relationship (Type, Print) 111 Penn Street Baltimore, MD O.C.M.E. other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 Burial 2 Cremation 3 Removal from State permit, Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 X Other (Specify) in state 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Ronald S. Wade State Anatomy Board 655 W. Baltimore Street mans. lBaltimore, MĎ 21201 MUCK Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Navcotec ntoxica **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): igned by the attending physician be detached for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Per 2 No has 1X Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence & Other (Specify) Scene Hospital: 1X Yes 2 □ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation Falinium d M 1 Natural UNKUOWN 5/3/105 1 ☐ Yes 2 ☑ No 2 Accident the Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. 18 - vity) . To und in 281. Location (Street and Number or Rural Route Number, City or Town, State) Town Bach filled in by 4 - Homicide within 24 hours a

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completely filled 12 MUDWAYY 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 💯 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME UV June 1 2005 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month 32. Registrar's Signature Day. State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Physician 10:25-AM Dolores 2005 Μ. Toth /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare- Cromwell Center Parkville Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1□M XXF Days 212-28-6813 73 Director November 22, 1931 MD. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show MD Baltimore Rosedale 1 Yes 2 No Funeral Director traumatic event, the Medical Examiner must be notifi-10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8210 Sagramore Road 21237 USA 11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married I ☐ Yes XXNo If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛛 No SpecifWhite Specify: Completed by 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pegas 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Mean Injury or other traumatic event, the Means Injury or other traumatic event, the Means Injury or other traumatic event, the Means Injury or other traumatic event, the Means Injury or other traumatic event. Elementery/Secondary (0-12) College (1-4or 5+) 12 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Bailey Hazel Hursterman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Bucci Daughter 9633 Baron Place, Rosedale, MD. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 16 Oak Lawn Cemetery $20\bar{0}5$ Dundalk, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of DUndalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner ascular Accordent Examine The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy has ZXINO 1 ☐ Yes 2 No 1 Yes or Attending Physician: diractor. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this : After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Director: A d in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital within 24 hours a To the Funeral Completely filled edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Type, Print) 30. Name and eddress of person who completed cause of deeth (V B(Vd 305 #00000U 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

			1 - For State Registrar	State of Marylar	nd / Dep		f Health and	Mental Hyg	•	23340
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Lass Roebuck Truit 4a. Facility Name (If not institution, give Prince 6 eag	t	tal	4b. City, Tow	n, or Location of Dea	2. Date of Dea Month	Day Von	3. Time of Death A 11-45 M Secrycs
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Ore, Mal ss 1 and 2 st of Health and	Item 27 is n r other traun		19a. Informant's Name/Relationship (7) Carmen Roebuck 20a. Method of Disposition	(Wife)	63		erry Way,		r, City or Town, State, Zij MD 20735 20c. Location - City or T	
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To the Ho	To the Fur completely	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis of examinand manner stated.	ation and/or in	vestigation, in r	ny opinion, death occ	curred at the time, d	ate and place, and due to go and Date signed (Month,	o the cause(s)
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	/Medic Examir		Janice Ar 4a. Facility Name (If not institution, give s		t	4b. City, Town, o	or Location of Death	July 6,	2005 4c. County of Dea	6:25 P. M				
	LXamii	ici	3351 Falls Road			Baltimo								
	Funeral Director		5. Social Security Number 215-44-0995 Usual Residence of Decedent	7. Age	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 22,	9. Bi 1944	rthplace (State or Foreign country) Maryland				
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Jre,	- I a 5		Mrs. Joanna Howe (sister) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 1307 Northview Road, Baltimore MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place)											
imo	Pages ment of l ant: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	*		, 2005	Baltimore	, Maryland				
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	Physician /Medical	2	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each lin	19.	ИĮ	ig, such as surales	or respiratory arres		Interval Between Onset and Death				
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rds, P	sign d be	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the u	nderlying cause giv	ren in Part I.		cco use contribute to	o the cause of death?				
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)	To the within 2 To the complet	W	29b. Signature and title of certifier Wall	Sommen	, M.D.	29c. Licens			J. Date signed (Mont	h, Day, Year)				
h			30. Name and address of person who co		eath (Item 23a) (Type, 200 E.	Print)	2016 Lel St	peut.	# 650, 8	WHI more				
	Sta Registr	-	31. Date filed (Month, Day, Year) JUL 1 8 206		nr's Signature	mede		/	N	102118				

4b. City, Town or Location of Death

JULY

4c. County of Death

Funeral Director with the Maryland 28a-f show other traumatic event. I've Medical Examiner must be notified at ŏ Items 23a filed within 72 hours after death Baltimore, Maryland 21215-0036 ŏ "natural" at Hygiene. 12 should be fill and Mental H I la marked of Pages 1 and 2 should item 27 i ...

Physician

/Medical

Examiner

4a. Fecility Name (If not institution, give street and number)

permit. Page Department of Important: If any injury or once. Pnysician /Medical Examiner

Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed Box 68760, P.0. ρ Division of Vital Records, Be Completed page 2 should Hospitel or Attending Physician: director, Certification: To death. after death Director: filled in by the 24 hours a within 24 ho To the Fund completely f

BALTIMORE, MD YARBER HESPITAL BALTIMINE | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | June 19 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreig Country) 1 □ M 2 X F 190 28 7831 Yrs. 68 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 4823 Pennington Avenue 21226 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: White 3 Widowed 4 N Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jacob Benko Louise (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenda Miller / Daughter 4823 Pennington Avenue Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Pk7/19/2005 Glen Burnie, Maryland ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 namerou 23a. Part1. Enter the disease, or shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAYS CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) Due to (or as a consequence of): EXACERBATION EMPHYSEMA TEAMS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) SMOKING YEARS that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 res 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 E No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pes 2 No 28c. Injury at Work? 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person (ho completed cause of death (Item 23a) (Type, Print)

ZIMMER

31. Date filed (Month, Day, Year)

JARBOR HOSPITAL

D57093

3001 S HANDVER ST

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DIVISION OF VICAL DECOLUS, F.O. DOA 007 00,	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

	1	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N2 0 15 23343
Physicia /Medica Examine	n al-	1. Decedent's Name (First, Middle, Last) VIVIEN IRIS LUCK TRENT 2. Date of Death Month Y 10 2005 3. Time of Death 1:55 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ADDITION OF CAMONICAL IN
Funeral Director		MARINER HEALTH OF CATONSVILLE CATONSVILLE 5. Social Security Number 230-50-0184 6. Sex 1 Months Days Hours Min. Months Days Hours Min. (Month, Day, Year) 12/31/1935 9. Birthplace (State or Foreign Country) VIRGINIA
28a-f show officed at	Director	Usual Residence of Decedent 10a. State
238	a l	10g. Citizen of What Country? 9222 TURNBULL ROAD 21133 11. Marital Status 1 Never Married 2 M
ien "natural", or Items Medical Examinar m	Completed by	1
d off	To Be Con	12TH NURSING TECHNICIAN JHH/ST. AGNES ER 17. Father's Name (First, Middle, Last) JAMES RALPH LUCK STHEL MAE THOMAS
ealth and m 27 is m ner traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FAITH B. TERRELL/DAUGHTER 9222 TURNBULL RD, RANDALLSTOWN, MD 21133
Department of Health a Irrportant: If Item 27 is any injury or other traitories.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of MD VETERANS CEM 7/18/05 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 4 Donation 5 Owings MILLS MD 21. Signature of Pure Rank Function - City or Town, State 20c. Location - City or Town, State
ysician Medical		23a. P.M. 5m of the sease, or complications that caused the soft of rear for liure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death disease condition resulting in death) Due to (or as a consequence of):
bur icia	icai Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):
attending pr for use as ti	hysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery Month Day Year
igned be dei	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - SWGAF 12 11 Yes 2 No 3 Probably 4 Unknown
ficate has bee r, page 2 shor	Completed	- SATICATIA TROM LEFT FOOT CANCLES 110 STORY OF JASSES. 24a. Was an autopsy performed? 1 Yes 20 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 20 No
this cert	tion: To Be	25. Was case referred to medical examiner? Yes 25 No
eral Director	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
thin 24 ho the Fun mpletely (Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [Check only one] Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tigle of certifier 29c. License number 29d. Date signed (Month, Day, Year)
¥ 6 8		2010
5		RUBEN REDER M.D. 7445 FURNACE BRANCH RD GEORGE BURNIE MIL Z1060
Stat Registra		31. Date filed (Month, Pax, Year) 32. registrar's Signature

			Amend Ite	State of Marylans 10a, b, c, e	and/Depa f, per Cel	irtment of Line C8	lealth and 1 9 11 117 Death	Mental Hy 05dhb	giene Reg. 2 00	5 23	1344
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	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. In:	side City Limits
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	items items	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Rad Blad	e - American Ind ck, White, etc.	ian,
20	rs aft	by F	MXNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2/CXNo If Yes, Give Yeer or Dates:	1	☐ Yes 2☐ No	Specify:		Specify	/:	
9	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or flems 23a or 28a-f show ther than "natural", or flems 23a or 28a-f show sht, fle Medical Examiner must be notified at		15. Decedent's Ed	ucation		ent's Usual Occup			16b, Kind of B	WHITE usiness/Industry	
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21	filed with Hygiene. ther than	Completed	12		CLER	CAL			OFFIC	CE WORK	
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Z Z	should be fed Mentel Barranked of	٦ و	JAMES WHALEN 19a. Informant's Name/Relationship (T	Compa (Colina)	40h Mailia			HOLLORAL		0:1 7:01	
Ma	nd 2 sho elth end 27 is me r traum		THOMAS WILEY	ype, runt)			end Number or Ru DR. TIM				'
ē,	₽ ₹ ₽ ₽		20a. Method of Disposition		o. Place of Dispos	sition (Name of	-	Date		· City or Town, St	ate
E	Pege ent o nt: If ny or		1 ☐ Burial 2/ [X] Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place CREMATORY		7.13.05	RAITTN	MD, MD	
Baltimore,	nit.		21. Signature of Funeral Service Licent		. 22	Name end Addre	ss of Facility		DINDILL	iokii, Iib	
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			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only			Appro	oximate val Between				
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	tificate be executed g physician and es the buriel-transit	Examiner	Sequentially list conditions,	b. Due to	o (or as e conseq	uence of):					
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P.0	thet the dended by the eached	hys	Tarrii. Other eignineant conditions co	initibuting to death but not i	resulting in the di	denying cease giv	en in ranti.		Yes 2□ No	3 ☐ Probably	4 Unknown
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)	To the Hospital or Attend within 24 hours efter deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	and manner stated.	_	29c. Licens	e number		29d. Date signe	d (Month, Day, Y	'ear)
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1	, 0	1	30. Name end address of person who c	ompleted cause of death (I	tem 23a (Type,	Print)	-46/			2,200	~
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DHMH 16 Rev 6/95

Terrona williams

		1 - For State Registrer				Certifi	cate of	Death			Reg. No	200	5	2334
Physici	ian	Decedent's Name (First,	Middle, Last)							2. Date of Do Month	Da		'ear	3. Time of Dea
/Medi Examir		TERRENCI 4a. Facility Name (If not ins		WILLIA	MS	4h	City, Town, o	r Location o	of Death	July		. County of	Death	530
	iei,	Sinai Hos 5. Social Security Number	()	- Bult		re	1 11	/mo/	e	8. Date of Bi		N/1	A	ace (State or Fo
Funeral Director		291-54-456	10\$		49		nths Days	Hours	Min.	(Month, D	a <i>y, Year)</i>		Count	49
*		Usual Residence of Deced			100 Cib	y, Town or Locatio								
f sho	ō		amil	ton		CINCINATI								d. Inside City L 1 X Yes 2
sa or 28e-f show	i Director	10e. Street and Number 516 BESSING				11	of. Zip Code 45240					tizen of Wh.	at Count	ry?
Hygiene. ther then "natural", or Items 23a or 28e-f show ont, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 25 3 Widowed 4 Div	Married	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		If Yes	Decedent of H s, specify Cuba es 2 X No	lispanic Origan, Mexican S <i>pecify:</i>	gin? (Spec i, Puerto P	cify Yes or No Rican, etc.)	0-	14. Race - Black, SpecifyB	White, e	itc.
h and Mental Hygiene. 7 is marked other then "natural', traumatic svent, the Medical Ex-	Completed	(Specify only	cedent's Educ highest grade	e completed)		16a. Decedent's (Give kind life. DO N	Usual Occup of work done IOT use retired	during mosi	t of workin	g	16b. K	ind of Busin	ness/Ind	ustry
giene er ths	mo	Elementary/Secondary (0-12)	College (1-4or 5	0+)	SECUE	RITY GU	ARD				SECUR	ITY	
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Department of Important: If I any injury or once.		21. Signature of Funeral S	ervice License	"Mr t										F.H.,
veisian		23a. Par 1. Enter the disea shock, or heart failure Immediate Cause (Final	ase, or compli e. List only on	cations that caused le cause on each lin	the death	n. Do not enter the		g, such as	cardiac or	respiratory a	ırrest,			Approximate Interval Betwee Onset and Dea
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			For	State of Maryland / Depa		ental Hygi	ene	
			Registrar	Cei	rtificate of Death		g. No 2 U D 5	23346
ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Windsor		2. Date of Death Month July 13	Day Year	2:27 P M
	Examin		4a. Facility Name (If not institution, give st		4b. City, Town, or Location of Death	•	4c. County of Death	
			Prince George Hos	pital	Chever1y		Prince (
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthday) M 2FVF 58 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Oct 1,	Year) 9. Birth	place (State or Foreign ntry) nington DC
	p		Usual Residence of Decedent	1111 30		OCL 1,	1940 Wasi	iriigton be
	rylan	_	10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	8a-f s	cto	Maryland Prince G	eorge's Upper Ma				1 ☐ Yes 2 ☑ No
	with th	Dire	17204 Nottingham	D 1	10f. Zip Code		og. Citizen of What Cou	
	s 234	erai	17204 Nottingham		20772		United Stat	
	fter d	Funeral Director	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
Ö	ral', o	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give XX Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Whi	te
5	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, If a Medical Exertical retinest the rediffed at	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a. Dece	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ng	16b. Kind of Business/Ir	dustry
121	within	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)				
2	filled Hygie ther	ပိ	17. Father's Name (First, Middle, Last)		nan Resources 18. Mother's Name	(First, Middle, N	Supermarke	et
Maryland 21215-0036	id be ental ked o	To Be	Lawrence E. Hol	land		P. Sheg		
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Typ	pe, Print) 19b. Mailin	ng Address (Street and Number or Rura	l Route Number,	City or Town, State, Zip	Code)
	and 2 saith a n 27 is		Hugh P. Windsor (Nottingham Road,	Upper M	arlboro, MD	20772
ore	of He		20a. Method of Disposition 1. DBurial 2 □ Cremation 3 □ Re	20b. Place of Dispo cemetery, crei	esition (Name of matory or other place) July 19	² 2005	20c. Location - City or T	own, State
Ë	. Pag tment tant: jury c		'4 ☐ Donation 5 ☐ Other (Specify)	Maryland	Veterans Cemeter		Cheltenham,	
Baltimore,	percit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Exerciter mastice notified at once.		21. Signature of uperal Service Licente The Transfer of the Service Licente The Tra		2. Name and Address of FacilityLee Llexandira Ferry Ro			
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	callous that caused the death. Do not ent	er the mode of dying, such as cardiac of	r respiratory arre	est,	Approximate Interval Between Onset and Death
F	Physician	į ų	Immediate Cause (Final disease in condition resulting in death)	macadoba	182			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	4:)4
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	milling		-	Hr.
	uted d ansit	Examiner	cause. Enter Underlying Cause (Ciscase of injury that initiated events	De 0 = 1 2000	O. Ins)		l.	2/4
o,	an an	Exa	resulting in death) Last	Due to (or as a consequence of):				20
8760,	icate be executed physician and the burial-transit	dicai	d	Dupon of the				421
9	entific ding p		IF FEMALE:	3c. If yes, outcome of pregnancy			1	•
Вох	atten for u	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Fetal death 3 [Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
o.	the d	hysi	1 ☐ Yes 2∏No 9 ☐ Unknown	9□ Unknown				
S, D	The law requires that the death certifi tte has been signed by the attending i vage 2 should be detached for use as	by P	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to t	
ğ	w require been sig should b		arthrehs,			1 ☐ Ye	s 2 No 3 Pro	bably 4 Onknown
Vital Record	e law ru has be je 2 shi	Completed				24a. Was ar autops	y prior to co	opsy findings available ompletion of cause of
<u>س</u>		Con				perform 1 Yes 2	ned? death? □No 1 □ Yes	2□ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	osnital 7777	26. Place of Death			
ō	Phys this ral dia	1. To	1 ☐ Yes 2 🔀 No	ospital: XX Inpatient 2 EP/Outpatien 28a. Date of Injury 28b. Time o			nce 6 Other (Speci w injury occurred	fy)
on	Attanding Phy r death. actor: After thi by the funeral oy the funeral o	tion	1 Accident 5 ☐ Pending investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	r Attar er dea ractor by the	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Sta City or Town	reet and Number or Run State)	al Route Number,
	Hospital or 24 hours afte Funaral Dir tely filled in I	O	TV V			,		
	To tha Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fi	edicai	29a. Certifier 1 1 A Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the ca ed at the time, da	tuse(s) and manner as s ate and place, and due t	stated. o the cause(s)
	To tha within 2.	M	29b. Signature and title of certifier	·	29c. License number	25	9d. Date signed (Month,	
)	5		Thomas It	elds DVD	D01923	(July 14.0	2005
1	5		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type,	Print)	· · · · · · · · ·	AC	
1	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	29c. License number DO 1923 Print) Ma (2026 Mi)	4001		
	Regist		31. Date filed (Month, Day, Year) JUL 1 8 2005	Been 15 1900				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death July 2005 **Physician** Рм 13 5:30 Warren C. Wood, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 14118 Bear Creek Drive 8. Date of Birth (Month, Day, Year)

1941

27, 1941 Montgomery Boyds If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 ☐ F 505-52-0945 64 Director Nebraska Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show item 27 is marked other than "natural; or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Boyds 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14118 Bear Creek Drive 20841 United States Completed by Funeral 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ☐ Yes 2 Yes, Give 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: Specify: White 3 ☐ Widowed 4 N Divorced Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Director of Old West
Regional Division 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Warren C. Wood, Sr. Della M. Reeder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. Plihal / Daughter 15204 Redgate Drive, Silver Spring, Maryland 20905 of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 July 16, 2005 ō <u>=</u> 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or once. Montgomery Crematorium, Inc. Bethesda, Maryland * 4 □ Donation 5 □ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service-Licensee Ungelette Born M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a I be detached f P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 shoułd Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛱 No Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Certification: To 1

Yes 2□No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. in by 4 Homicide City or Town, State) within 24 hours at To the Funeral D completely filled i 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 1 Certifying Physicien: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the I To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mo 10 mg D15236 July 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carl I. Margolis, M.D. 11125 Rockville Pike, #211, Rockville, Maryland 20852 32. Resistrar's Signature 31. Date filed (Month. Da Year) State 2005 Registrar

			For State Registrar		State of I	Maryland	•	artmen rtificat			ind M		Reg. No2 ()	05	233	48
	Physicia	an	Decedent's Name (7	IMLIN	ı			2. Date of Dea Month JULY	13,	2005	3. Time of 7:55	
7	/Medic	al	4a. Fecility Name (If n	BELLE	street and numb	er)				Location o	f Death	OULT	T	ty of Deeth	7.55	Α
	Examin	er		PIKESVI			JME			SVILL			B <i>P</i>	LTIMO	RE	
Ą.	Funeral Director		5. Social Security Num 219-42-2	415	M 2 F 7.	Age (In yrs. I	ast birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birt Month, De JULY 28	, Year) 3, 1911	9. Birthi Coul	place (State or ntry)	r Foreign D
	/land ow		Usuel Residence of D 10a. State 1	ob. County		10c. City	, Town or Lo	ocation						1	I0d. Inside Cit	y Limits
	er death with the Marylar Items 23e or 28e-f show er meat be notified at	ctor	MD	ВА	LTIMORE		BAL	TIMOR	Ε						1 🗌 Yes	2 No
	or 28	Director	10e. Street and Numb					10f. Zip	Code				10g. Citizen o	f What Cou		
	eath v	eral	73 RIVE	R OAKS C	IRCLE	ant Ever in U	S 13	Was Dece	dent of Hi	212		cify Yes or No	- 14. R	ace - Ameri	USA can Indian.	
036	hours after death with the Maryland tural', or Itama 23a or 28a-f show al Egal it at must be notified at	by Funeral	1 ☐ Never Married 3 🂢 Widowed 4	2 Married	Armed Force 1 Yes 2 If Yes, Give Year or Date	No No		If Yes, spe		Specify:	, Puèrto	cify Yes or No Rican, etc.)	Spec	lack, White,	etc. WHIT	E
Q 2	72 ho	eted	1 (Specify	5. Decedent's Edu only highest grad	cation e completed)		16a. Dece (Give	kind of wo	rk done o	lurina most	of work	ng	16b. Kind of	Business/In	dustry	
121	within 72 ene. than "na!	Completed	Elementary/Second		College (1-4	or 5+)	life.	EMAKE	se retired)			OWN F	IOME		
<u>d</u>	Hygid other	Be Co	17. Father's Name (F				11011	L. 17 (1 (L		18. Mothe	r's Name	(First, Middle,				
/lan	should be and Mental s marked o umatic eve	To B	NATHAN				CAP	LAN		ES	THEF				SKLAI	R
Σ	permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiens. I have the Important: If item 27 is marked other than "natural", or It amy njury or other traumatic event, the Medical Edging. Once.		19a. Informant's Nam GERALD	e/Relationship (Ty			73	RIVER	OAK	S CIF	CLE	- BALT	MORE,	MD 21	208	
Baltimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Dispo	sition Cremation 3 🔲 F	Removal from St		lace of Dispo)ate	20c. Location	-		
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ļ			23a. Part1. Enter the shock, or heart Immediate Cause (F	failure. List only o	ications that cau ne cause on eac	ised the death th line.	n. Do not en								Approximate Interval Bety Onset and D	e ween
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3760,	ate be executed hysician and the burial-transit	Cal	that initiated events resulting in death) La	st [Due to (or	r as a conseq	uence of):									
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Vital Record	us or or	Completed			Dem	nonco						24a. Was		b. Were aut	opsy findings a	available
R		Com										perfo	ormed?	death?	2□ No	4430 01
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referre		Hospital:				Oth Oth		of Deat	h (Check only	опе)			
of	Phys this ral dii	. To	1 ☐ Yes 2 ☐ N 27. Manner of Death	0	1 U In	patient 2 Injury	ER/Outpatie		OA Dur	4 3114	irsing Ho	me 5 Resi			ify)	
ion	Attending Phy r death. ector: After thi by the funeral o	ation	1-Natural 2 ☐ Accident	5 Pending investigation	28a. Date of (Month	, Day Yeer)	Injury	М	Wor	k? Yes 2□	No					
Division		Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place o building	of Injury - At h	ome, farm, s	treet, factor	y, office			28f. Location (City or To	Street and Nu wn, State)	mber or Rui	al Route Num	aber,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in	edical	29a. Certifier (Check only one)	Certifying Phy	sicien: To the tiner: On the bas	is of examina	owledge, dea ation and/or i	ith occurred	at the tirn, in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and date and place	manner as e, and due	stated. to the cause(s	3)
	To the within 2 To the complet	Me	29b. Signature and t	tle of certifier						e number			29d. Date sig			
	<			4	mo				07	2750	09		7113	105		
•	4		30. Name and addre	ss of person who o	pleted cause	Jutt	Con	Print)	1	838	(Tiene	Tru	e Re	1 211	208
	St Regist	ate	31. Date filed (Month	, Day, Year) 1871	05 32.	gistrar's Signi	ature	Sark.	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amended #10a per fh/wichd/ Certificate of Death 7-1-05/dls Reg. No. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Enrique Varado /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gkn Burne If Under 24 Hrs. Arunde Arundel North Hospital Anne 5. Social Security Number 799-999 If Under 1 Year Months Days 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours MM 20F Director Yrs. Usual Residence of Decedent the Marylend 10a. StateMD 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, it is Medical Eractical must be portified at Gua Dalisbury 101-Zip Code 1 Yes 2 No Direct 10e. Street and Number 10g. Citizen of What Country? Guatamala 21804 25 A ST Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Alvarado, Enrique 1 Never Married 2 ☐ Married 1 Yes 2□ No Specify. δ 4 i Spanic 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6tharal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental ingacia 19a. Informant's Name/Restionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Ie any Injury or other trains once. 925 Church Schiburg, -SON ml 218 crxles 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date City or Town, State 1 Burial 2 Cremation 3 Removal from State Gerkunde 4 □ Donation 5 □ Other (Specify) huken 21. Signayore of Funeral Service Licensee 22. Name and Address of Facility Sabelle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death neumor **Physician** /Medical Due to (or as a consequence of): Examiner con con x a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed

	1 🗌 Yes
24a	. Was an
	autopsy performed?

2 No 3 Probably 4 Nnknown

24b. Were autopsy findings available prior to completion of cause of death? 25 No

2 No

26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes

28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

" Natural

2 Accident

4 | Homicide

3 ☐ Suicide

29a. Certifier

29c. License number 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient

State Registrar

tilled in by the funeral director,

within 24 hours after death. To the Funerel Director:

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o

Division

Be

Certification; To

31. Date filed (Month, Day, Y 1 2005 °C 32. R

strar's Signature

			1 - For State Registrar	State of Mai		artment of F			giene Reg. 2005	23350
			Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	Physicia /Medic		LOUISE	C.		ADDIS	ON	June	25,2005	8:02P M
	Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, o		ath	4c. County of D	
			70 Moore Drive 5. Social Security Number 6. Sex	7.4	// to at blints do		Ville	S 0 5 (5:		Jomery
	Funeral Director			M 2AF	(In yrs. last birthday, 75 ^{Yrs.}	Months Days	Hours Mir	n. (Month, Da	iv, Year) 0,1930 N	Birthplace (State or Foreign Country)
			Usual Residence of Decedent					vaii. 20	7,1930 r	Maryland
	nyian		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Be-f.	Director	MD Montgome	ery	Rock	ville				1 TYes 2 No
	with the	Dire	10e. Street and Number 70 Moore Drive	0		10f. Zip Code	20050		10g. Citizen of What	
	ns 23	Funeral		2. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H	20850	Specify Yes or No	U.S. 7	A . merican Indian.
ထ	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or items 23a or 28e-f ahow other than "natural", or items 23a or 28e-f ahow event, the Madical Examiner must be motified at	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No	,	Was Decedent of H		nto Rican, etc.)		hite, etc.
21215-0036	ral', c	d by	3 AWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: E	Black
2-(natu	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of w	orking	16b. Kind of Busine	
12	withir ene. than	dmo	Elementary/Secondary (0-12) 8th	College (1-4or 5+)	etary Ai			Chestr	ut Lodge
ק	Hygi other	Be Co	17. Father's Name (First, Middle, Last)			scary m		ame (First, Middle,	, Maiden Surname)	
lan	Aental Aental rked tic ev	O B	Joseph Cooper				Car	rie Do	rsey	
Maryland	and N is ma		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mail	ing Address (Street	and Number or I	Rural Route Numb	er, City or Town, State	e, Zip Code)
∑ 	and 3		Peggy Hackey- Da	aughter	123	48 Quail	. Wood	Dr Gern	antown,	MD 20874
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: if item 27 is marked other than "natural; or items 23a or 28e-1 show any lour or other traumatic event, the Mudical Examiner must be notified at a face.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re	moval from State	1	matory or other plac		Date	20c. Location - City	
Ē	rtmen rtant:	į ų	*4 □ Donation 5 □ Other (Specify) 21 ✓ Ignature of Funeral Service Livense	-0-		k Mem Pa	irk 7/	6/2005	Olney,	Maryland Home P.A.
Ba	permi Depa impol		21 Ignature of Pulleral Service Electrics	Survey						e,Md20850
			23a. Part1. Enter the disease, or complic	ations that caused t	he death. De not en					Approximate
	Physician		shock, or hearfailure. List only one Immediate Cause (Final disease or condition			1005 14	KADT	EAI	LUPF	Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a	NGEST consequence of):	08 61	EMICI	(/ (.	-0100	
	Examiner	_	Sequentially list conditions, b.	CHRI	DNIC O.	BSTRUC	TIVE	PULM	LOMARY	
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as a	consequence of):	DISE.	ASE			
	al-trar	Exan	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):			<u> </u>		
8760,	cate be executed physician and the burial-transit	dicai	d.							
9	rtificat ng phy as th	Medi	IF FEMALE:							
Вох	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome o	Fetal death 3	⊒Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
o.	the a	ysici	1 Yes 2 No	4☐Pregnant at ti 9☐ Unknown	me of death 5	Other (specify)			Worth	Day Feat
Δ.	The law requires that the death certifi tie has been signed by the attending page 2 should be delached for use as		Part II. Other significant conditions cont	ributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco usa contribute	e to the cause of death?
Records,	quires n sign ald be	d by						1 🗆	Yes 2.2No 3□	Probably 4 Unknown
CO	aw requir s been s s should	ojete						24a. Was		autopsy findings available
Re	The law ate has page 2 s	Completed						autoj perfo	prior death	
Vital	ılcian: Th certificate rector, paç	Bec	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o		
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ No Ho	spital:			4 Nursing		dence 6 Other (5	pecify)
uc.	ling After une	ion	27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (Wor	yat k? Yes 2 □ No	28d. Describe	how injury occurred	
Division	ten leat tor: the	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home, farm, s		163 2 1140	28f. Location (Street and Number or	Rural Route Number.
Ö	o te	Certi	4 Homicide	building, etc.		7,		City or To		
	To the Hospitei or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1. Certifying Physical Continuous Certifying Physical Certification Physical Certification Physic	ician: To the best of er: On the basis of and manner state	examination and/or in	th occurred at the time	me, date and pla- ppinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)
	To the Mithin To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Me	onth, Day, Year)
	10		1 Trus	Son	omo	Dog	571	24	6/2	9/05
	Y		30. Name and address of person who con	npleted cause of de	ath (Item 23a) (Type	, Print)				
			DR. Bao, MD 8	3600 Old	Georget	own, Rd	Beth	e sda, M	D 20914	
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registra	Signature A	BALLE				

			1 - For State Registrar	State of Man		artment of rtificate of			iene eg. N2 0 0 5	23351
I	Physici /Medie		1. Decedent's Name (First, Middle, Last) WAREN E.	BLAIR				2. Date of Deal Month	Day Year	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give through a facility ALA) UNTY SEN 5. Social Security Number 6. Sen	NEWN INSP	TTAZ	COLUN	or Location of Deatl		4c. County of Dea	Ð
	Funeral Director			XM alle	39 Yrs.	Months Days		8. Date of Birth (Month, Day, June 23	, 1916 I1	thplace (State or Foreign ountry) linois
	e Marylen 8e-f show titled at	ctor	MD 10b. County HOWARD	10	Oc. City, Town or Lo WEST	rrien FRIENDSH	IP			10d. Inside City Limits 1 ☐ Yes 2X No
.0036	d within 72 hours after death with the Marylend jiene. r then "neturel", or Items 23a or 28e-1 show the Medical Examinat must be notified at	ed by Funeral Director	10e. Street and Number 1757 HEATHERWOOD 1 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu	12. Was Decedent Eve Armed Forces? 1 (TYYes 2 □ Not If Yes, Give Year or Dates: KC	win U.S. 13. WII brean	1 □ Yes ZXNo	Hispanic Origin? (S ban, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	0g. Citizen of What Co U • S • A • 14. Race - Ame Black, White Specify:	arican Indian, le, etc. White
21215-	within ene. then "	Completed	(Specify only highest grade		16a. Dece (Give life. Jud		pation during most of wor ad)	king	16b. Kind of Business. Law	/Industry
Maryland 21215-0036	othe ent.	0	17. Father's Name (First, Middle, Last) Henry A. Bla:				Mae	ne (First, Middle, M Idella	Spratt	
nore, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Importants. If item 27 is marked any Injury or other treumatic evonce.		19a. Informant's Name/Relationship (Ty Marion Owens/ Frie 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R	end Removal from State	1757 20b. Place of Disponsion Commetery, cre-	HEATHER District (Name of matory or other pla	WOOD WAY,	P.O. BOX	20c. Location - City or	Town, State
Baltimore,	permit. Pa Departmen Importent: any Injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Serve Licens	TO		2. Name and Addr		SEPH GAM	ARLINGTON, LER'S SONS DC 20016	
	Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart tailure. List only or Immediate Cause (Phal disease or condition resulting in death)	ACU"TE	KESTIRA		ing, such as cardiac		est,	Approximate Interval Between Onset and Death
8760,	Examiner	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	NITY AC	ر ۱۷ نالمیز ای	PNEUW	57V (17		5 1) 1245
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	33c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	ру		23d. Date of del Month	ivery Day Year
Δ.	quires that in signed by uld be deta	by	Part II. Other significant conditions cor	ntributing to death but n	ot resulting in the u	enderlying cause g	ven in Part I.		pacco use contribute to	the cause of death?
of Vital Records,	(D) L.L.	Completed	DENGENTIA					24a. Was an autops perform	y prior to o	utopsy findings available completion of cause of
ion of Vita	Attending Physician: T r death. ector: After this certificat by the funeral director, pa	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	dospital: 1 Unpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	f 28c. Inju	her: 4 🗆 Nursing H	th (Check only only ome 5 ☐ Reside 28d. Describe ho	ince 6 □Other (Spe	cify)
Division	2 de 2	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (\$		reet, factory, office		28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
	Hospit 4 hour Funere ely fille	edical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of m ner: On the basis of ex and manner stated	amination and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, death occu	, and due to the ca rred at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
	To the To the Complet	Σ	29b. Signature and title of certifier	my		29c. Licen	se number	29	O6/30/	
	("		30. Name and address of person who co	No. 10724	CITTLE	PATU KON	T PRWY ,	Cozumsi		21344
H	Sta Registi		31. Date filed (Month, Day, Year) JUL 01 200	32/Registrar's	Signature	arte)				

			State of Maryland / [1- State Registrar	Depa		Health and M	lental Hy	giene	_	233	52
157	₹.		Decedent's Name (First, Middle, Last)				2. Date of De.	ath		3. Time of	Death
	Physicia		MELVIN MARVIN BROWN				JUNE 2	20, Day	2005	8:50	A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death	ound .		County of Deat		
	Examin	٠.	6610 Calmos Street		Capito]	l Height	s	Pr	ince (George	s
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da			nplace (State ountry)	
	Director		251-24-4178 ★ M 2□F 80	Yrs.	Months Days	Hours Min.	11/29	/19	24 S.	Carol	ina
	pu .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow							404	5 a 5 to .
	sho	5			. Height	t c				10d. Inside C	2 □ No
	the N	ect	MD Prince Georges Capi		10f. Zip Code			10- 04			
	with with	Funeral Director	6610 Calmos Street			20743		rog. Cit	zen of What Co USA	untry?	
	ns 23	era	11. Marital Status 12. Was Decedent Ever in U.S.	13. \	1		ecify Yes or No		14. Race - Ame	nican Indian	
(0	r Itan	듄	Armed Forces? 1 □ Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Hispanic Origin? (Spean, Mexican, Puerto	Rican, etc.)		Black, White	e, etc.	
030	al', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1□Yes 2M2 No	Specify:			Specify: Bl	ack	
5-0	filed within 72 hours after death with the Maryland Hygiene. khar than "natural", or Itams 23a or 28a-f show khar than "natural", or Itams 23a or 28a-f show ant, I've Medicul Exarril ver must be rediffed at	Completed by	15. Decedent's Education 16a. (Specify only highest grade completed)	. Deced	dent's Usual Occup	pation during most of work	ina	16b. K	nd of Business/	ndustry	
21	ithin Den.	npigu	Elementary/Secondary (0-12) College (1-4or 5+)	life. L		during most of work d)	9				
12	filed with Hygiene. other ther ent, I'e N		12		Labor	Worker	(E1 - A1) 4 II		rivate	_	
and	be fi	Be	17. Father's Name (First, Middle, Last) Edward Brown			18. Mother's Name					
ž	should be nd Mental markad o	2		h Mailie	a Address (Ctrast		oldia		OX	"- Code)	
Maryland 21215-0036	d 2 h a 7 is 7 is		1111		-	and Number or Rura S St, Ca					
	is 1 and 2 if Health Item 27 other tra				sition (Name of natory or other place		Date	20c. Lc	cation - City or		
no	00					etery 6-2			Dee,	4%	
Baltimore,	교본관등 .	1	21. Signature of Funer Service L. ensee	_			-		th Car		
ä	Depar Impo any ir		+	3	605 14t	rofession ch St. N	nai Fu W Wash	ner.	aı Ser C 2001	vice 0	
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.							Approximat Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition PROSTATE CANC)							Onset and	Death
	/Medical Examiner		resulting in death) Due to (or as a consequence	of):			- · · · · · · · · · · · · · · · · · · ·				-
	Lammer	_	Sequentially list conditions, b.	-00							
	ed isit	Examiner	Due to or as a consequence cause. Enter Underlying Cause (Disease or injury	Offic							
	xecul and al-trar	хап	that initiated events c. resulting in death) Last Due to (or as a consequence	of):							
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89	ifficate g phy as the										
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	s deat he att ed for	sicla	1 Yes 2 No 4 Pregnant at time of death		Other (specify)	y			Month	Day '	Year
P.0	at the ded by the a	Physician/Med	9 Unknown								
ŝ,	ires tha signed I I be det	by	Part II. Other significant conditions contributing to death but not resulting in	n the ur	nderlying cause giv	ven in Part I.			se contribute to □ No 3 □ Pre		
Orc	w raqui been s should	eted							140 301	Doably 4 LI	DIIKHOWII
Records,	e law has b	Completed					24a. Was autop		24b. Were au prior to death?	topsy findings ompletion of c	available ause of
a	(0)						1 ☐ Yes		1 🗆 Yes	2 X No	
Vital	Sic Co	Be c	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Ou		Oth	26. Place of Death					
of); To	27. Manner of Death 28a. Date of Injury 28b.	Time of		ner: 4 □ Nursing Ho ny at	me 5 A Hesid 28d. Describe f			erry)	_
ion	Attanding in death. actor: After by the funer	atio	1 XNatural 5 Pending (Month, Day Year) I 2 Accident investigation	Injury		rk? Yes 2 □No					
Division	for Attand after death Diractor: /	tifle	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, str	eet, factory, office		28f. Location (S City or Tov	Street an	d Number or Ru	ral Route Nurr	ber,
	tal or A	Certification;	5 a.i.a.i.g, 6 i.a. (6,50 a.i.y)								
	To the Hospital of within 24 hours all To the Funeral D completely filled in		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination an	e, death	occurred at the tir	me, date and place, opinion, death occurr	and due to the ed at the time.	cause(s)	and manner as place, and due	stated. to the cause(s	s)
	o the lithin 2 o tha lo o tha lo omplet	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. Licens				e signed (Mont)		
	± ₹ 5		11/1 -th.)101235824			22, 200		
_	00		30. Name and address of person who completed cause of death (Item 23a)	(Туре.		,_0_20	J	OME	22, 200		_
(KU		IRA C. MARATHE, M.D., VAMC 50 IRV		•	W, WASHIN	GTON, D	C 20	0422/688		
	Sta	i	31. Date filed (Month, Day, Year) 82. Registrar's Signature	1	٠.						
	Registr	ar	JUN 3 0 2005 Seem & A	204							

				• •	R Indelible Ink. Ensure A Department of Health and 6.8-30-05 tas Certificate of Death	•	•	
				Sadzi per me 004	Certificate of Death			23353
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Michael R.	Barkdoll		2. Date of Death Month JUNE	Day Year 23, 2005	3. Time of Death 3:33P. M
	Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Deat	h	4c. County of Death	1
			9949 DOCTOR PERRY R 5. Social Security Number 6. Sex		I jamsville	8. Date of Birth	FREDERICK	alaa (Ctata a Carrier
	Funeral Director			W = 0 C	Yrs. Months Days Hours Min.		20, 1978	nplace (State or Foreign untry) MD
	e Maryland le-f show tifficd at	Director	10a. State 10b. County MD Frede	rick 10c. City, Town	or Location I jamsville			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th	al Dire	10e. Street and Number 9949 Doctor Pe	rry Rd.	10f. Zip Code 21754	10	g. Citizen of What Cou USA	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or Items 23e or 28e-1 show any injury or other treumatic event. If a Medical Execulty is the mail for instilling at ODGe.	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Pes 2 Valvo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: Wh:	, etc.
Maryland 21215-0036	I within 72 ho lene. r than "natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation 16a. College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) none	rking	none	ndustry
/land 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Ronald R. Bark	doll Sr.		ne (First, Middle, M. ine D. L	aiden Sumame) evassaur	
Mary	ind 2 sho alth and N 27 is ma or troums		19a. Informant's Name/Relationship (Type Ronald Barkdol	os, Print) 1 Sr. (Father)	Mailing Address (Street and Number or Ri) 9949 Doctor Peri	y Rd.,	City or Town, State, Zi ${f Ijamsvil}$	le, MD
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1 Burial 2 XCremation 3 R. 4 Donation 5 Other (Special)	amoval from State 20b. Place of cometer Smith	Disposition (Name of y, crematory or other place) asburg Crematory	Date 29 6 / 25 / 05	Smithsbu	rg, MD
Balti	permit. Departm Imports any inju		21. Signature of Juneral Service College	10x68-	किल्माकोप्तेषाकेऽा मिणिला 31 E. Main St.	son Fun Middle	eral Home	e 21769
I	Pnysician		Immediate Cause (Final disease or condition	cations had caused the death. Do not be caused on each line. Seizure disorde:	not enter the mode of dying, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	of):			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of	of):			l
,092	icate be executed physicien and s the burial-transit	cai	resulting in death) Last	Due to (or as a consequence of	of):			
.O. Box 68	The law requires that the death certificat ite has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	very Day Year
Ω_	uires that signed b ild be deta	by	Part II. Dther significent conditions con	tributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to	the cause of death?
al Records,		Completed				24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Vital	nysician: Th iis certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:	Other	ath (Check only one)		
o	ding Phys h. After this funeral di	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. T	tpatient 3 DOA 4 Nursing F lime of volume Work? M 1 Yes 2 No	lome 5 Residen 28d. Describe how	ce 6 Xther (Speci	(v) SCENE
Division	Hospitel or Attene 14 hours after death Funerel Director: tely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in I	edicai	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Exemin	ician: To the best of my knowledge, er: On the basis of examination and and manner stated.	, death occurred at the time, date and place d/or investigation, in my opinion, death occu	n, and due to the cau arred at the time, date	se(s) and manner as s e and place, and due t	stated. to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	1 -11	29c. License number	290	I. Date signed (Month,	Day, Year)
			1 M	1. 1	OCME	JU.	NE 25, 200	5
p 488	0		30. Name and address of person who col	- 15	Type, Print) 111 Penn Stre			
	Sta	te	JACK W. 7 31. Date filed (Month, Day, Year)	32. Registar's Signature			nore, rary.	Lairu ZiZUI
	Registr	_	JUL 1 4	2005	or Spend !			

_			1 - Stete Registrar	State of Maryl	_	rtificate of		Reg	. N2 () () [23351
	Physici	an	1. Decedent's Name (First, Middle, Last	•	-			2. Date of Death Month	Day Ye	
	/Medic Examir	al.	Jessie H 4a. Facility Name (If not institution, give		Ť	4h City Town or	Location of Death	June	30 , 20 4c. County of E	
	Exami	eı	Salisbury Nursing		Center	10.01,710.11,01	Salisbu		Wicom	
	Funeral Director		5. Social Security Number 6. Se 218–24–5647	x 7. Age (In) M 2점F 74	rs. last birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 8/10/193	(ear) 9.	Birthplace (State or Foreig Country) [aryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	Mary s-f sho	tor	Maryland Wicom	ico	Sharpt	own				1≹Yes 2□No
,	or 288	Jirec	10e. Street and Number			10f. Zip Code		100	. Citizen of Wha	t Country?
	s 23a	rai	603 Church Street			2186			USA	
,	be lied within 72 hours atter death with the Maryland Hygiene. d other than "natural", or tems 23a or 28a-f show event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	n U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Imerican Indian, Vhite, etc. White
	2 hour	ted t	15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation	16	b. Kind of Busine	
	within 7 iene. than "n he Medi	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	luring most of work)	ing		,
	Hygier Hygier Stherth	Cor	12. Father's Name (First, Middle, Last)		Secre	etary/Tre		e (First, Middle, Ma	edical (Corporation
		To Be	Robert Francis Hu	ıston			Una War		iden Sumame)	
	shou ind N imai	-	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mail	ing Address (Street a			City or Town, Star	re, Zip Code)
	and 2 salth a n 27 is		D. Bruce Bennighof	/son	60:	3 Church S	St., Shar	ptown, MD	21861	
•	iges 1 it of He if item or oth		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ F		cemetery, cre	osition (Name of matory or other place	θ)		c. Location - City	or Town, State
	artment of hortant: If ite		' 4 ☐ Donation 5 ☐ Other (Specify)	ادا	Cemeter		1757	05 S	harptown	n, MD
3	fino a		Signature of Funeral Service Licens		500	Name and Addrese Holloway	Funeral	Home Prof	essiona.	L Association
			23a. Part1. Enter the disease, or compl	ications that caused the d	ESP eath. Do not en	501 Snow ter the mode of dyin	Hill Rd.	, Salisbu	ry, MD	21804 Approximate
F	Physician		shock, or heart failure. List only of	ne cause on each line.	200	6.	10	· · ·	9	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a con	sequence of):	cias ?	1 Second	noy De	allow	georg
	Examiner	_	Sequentially flat conditions,	corport	ica.	Lead	Taelon	<u>'</u>		4201-
	ecuted and -transit	aminer	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence or):					/
		Exar	that initiated events resulting in death) Last	Due to (or as a con:	sequence of):					=
	death certilicate be ex e attending physician a ed for use as the burial			i						
:	ing ph e as th	Physician/Medical	IF FEMALE:	10,000						
,	eath certifici attending pl	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
1	be de	nysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	or death 5	Other (specify)				
	를 것 들		Part II. Other significant conditions con	ntributing to death but not	resulting in the u		n in Part I.	23e. Did tobac	cco use contribut	a to the series of death?
	ss that the gned by t e detach	2				inderlying cause give				a to the cause of death?
	equires that the de en signed by the a ould be detached t	ted by				inderrying cause give		1 A 765	2□No 3□	Probably 4 Unknown
	s been s					inderrying cause give		24a. Was an autopsy	24b. Were	Probably 4 Unknown autopsy findings available to completion of cause of
	The law requi ate has been s page 2 should	Completed				inderlying cause give		24a. Was an	24b. Were prior death	Probably 4 Unknown autopsy findings available to completion of cause of 1?
	The law requi ate has been s page 2 should	Be Completed	25. Was case referred to medical examiner?	losnital:		Othe	r /	24a. Was an autopsy performe 1 Yes 2 (and the Check only one)	24b. Were prior death	Probably 4 □Unknown autopsy findings available to completion of cause of ? Yes 2□ No
	Physician: The law requi this certificate has been s ral director, page 2 should	To Be Completed	examiner? 1 Tyes 2 No 27. Manner of Death	fospital: 1 ☐ Inpatient 2 28a. Date of Injury	P ☐ ER/Outpatie	nt 3□ DOA Dthe	or: 4 Mursing Ho	24a. Was an autopsy performe	24b. Were prior death	Probably 4 □Unknown autopsy findings available to completion of cause of ? Yes 2□ No
	ding Prysician: The Taw requi h. After this certificate has been s funeral director, page 2 should	To Be Completed	examiner? 1 Yes 2 No 27. Mannerof Death 1 Matural 5 Pending 2 Accident investigation	fospital: 1 ☐ Inpatient = 2	P ☐ ER/Outpatie	nt 3 DOA Dthe	or: 4 Mursing Ho	24a. Was an autopsy performe 1 Yes 2 Chack only one) me 5 Residence	24b. Were prior death	Probably 4 □Unknown autopsy findings available to completion of cause of ??
	ding Prysician: The Taw requi h. After this certificate has been s funeral director, page 2 should	To Be Completed	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	fospital: 1 ☐ Inpatient 2 28a. Date of Injury	2 ER/Outpatie 28b. Time of Injury	nt 3 DOA Dthe	at ? /es 2 \sum No	24a. Was an autopsy performe 1 Yes 2 Start (Check only one) me 5 Residence 28d. Describe how	24b. Wersen prior death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Probably 4 □Unknown autopsy findings available to completion of cause of ? Yes 2□ No
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	ding Prysician: The Taw requi h. After this certificate has been s funeral director, page 2 should	Certification; To Be Completed	examiner? 1 Yes 2 No 27. Manney Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	fospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - A	2 ER/Outpatie 28b. Time of Injury at home, farm, st	nt 3 DOA Dthe f 28c. Injury Work M 1 1	of: 4 Moursing Ho at ? /es 2 \sum No	24a. Was an autopsy performe 1 Yes 2 \(\text{The Notice of None} \) The State of Check only one) The State of Check only one) The State of Check only one) The State of Check only one) The State of Check only one) The State of Check only one) The State of Check only one) The State of Check only one)	24b. Were prior death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Probably 4 Unknown autopsy findings available to completion of cause of res 2 No specify) Rural Route Number,
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State Registrar WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 21804

31. Date filed (Month, Day, Year)

32. Postrar's Signature

JUL 0 1 2005

		1 - For State Registrar 1. Decedent's Name (First, Middle,		Marylan		artmen rtificat					Reg. N		5	23355
Physici /Medic Examin	cal		cicia I	Brown (ber)		4b. City,	Town, or	Location of	of Death	2. Date of Dea Month	Da 227	. County o		3. Time of Death 4.5/0 M
Funeral Director				7. Age (In yrs. 44		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt Month Da 04/22/	y 196	1	Coun	lace (State or Foreign try) yland
he Maryland 28a-f show culfied at	ector	10a. State 10b. County MD P • G	•		y, Town or Lo uitlan	d						t		0d. Inside City Limits 1 XYes 2 No
eath with (ns 23e or ?	Funeral Director	3533 Terrace Dri	ve #A	dent Ever in III	S 13 1	10f. Zip	2074		ain? (Sn	neitu Van ar No		U.S.	Α.	
ine, intally lated A 12.13-0030 stand 2 should be filed within 72 hours after death with the Maryland of Health and Merical Hygiene. If Health and Merical Hygiene. other traumatic event, the Maches Examination and be motified at	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 Yes 3 If Yes, Give Year or Da	ces? 2 X No		1□ Yes	200 No	Specify:		ecify Yes or No- Rican, etc.)		Specify:	White,	etc. ack
od within 72 l giene. er than "nat er, the Mode	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 11th	Education grade completed) College (1-	4or 5+)		dent's Usua kind of wo DO NOT us untan	rk done d se retired	turing mos ')	t of worki	ing	16b. K	ind of Bus	iness/Ind	ŕ
yidriu ould be file Mental Hy barked oth satic event	To Be (17. Father's Name (First, Middle, La Robert L. Brow	n					Ve	eree	(First, Middle, Harrod				
and 2 sh and 2 sh lealth and m 27 is m her traum	e j	19a. Informant's Name/Relationship Lawrence Bullard		1	7161	Cros	s St	reet;	£201;	Route Number	tvil	le, M	D 2	20747
Definition Pages 1 am Deportment of Healt Important: If item 2 any njury or other 2006.		20a. Method of Disposition 1 □ Burial 2√2 Cremation 3 1 □ Donation 5 □ Other (Spe	cify)	tate C	Place of Dispo emetery, crer erdale (natory`or o Tremato	ther place		06/29		Riv		e, I	_{wn, State} Maryland
Demit Depart Import any nj		21. Signal most Funeral Service Lie	telmo	W	P	.O.Box	416;	Suitl	and, 1	eman Fune Maryland	207		es	
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or co shock, Scheart failure. List or Immediate Cause (Final disease or condition resulting in death)	a POOR	101112	FFERE					or respiratory ar				Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence or as a consequence										
ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fetal int at time of d	Ideath 3□	Ectopic pr Other (sp						23d. Date Mont		ry Day Year
law requires that the as been signed by t	ompleted by Pl	Part II. Other significant condition THROM BO CYTO			ulting in the u			on in Part I.			obacco (e cause of death? ably 4 □Unknown
Attending Physicien: The law re death rector: Alter this certificate has be by the funeral director, page 2 sh	C									24a. Was autop perfor 1 Yes	sy rmed?	pri	or to con ath?	osy findings available inpletion of cause of 2 No
Physicial this certifical director	To Be	25. Was case referred to medical examiner? 1 Yes 2 Yo			ER/Outpatier			er: 4□ Nu		n <i>(Check only o</i> me 5 ☐ Resid		6 □Other	(Specify	·)
or Attending Falls of Atter death. Director: After in by the funeral	ertification:	27. Manner of Death 1. 1. 1. 1. 1. 1. 1. 1.		f Injury s, Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🔲 Y	rat (? Yes 2 □ I		28d. Describe h	now inju	ry occurred	d	
To the Hospital or Attending 8 within 24 hours after death after the troube for the formal Director: After completely filled in by the funer.	O	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of building	of Injury - At ho g, etc. (Specify						City or Ton	vn, State	9)		Route Number,
To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	Medical	one)	Physician: To the baseminer: On the baseminer and manner	sis of examina	wledge, death tion and/or in	vestigation,	in my op	oinion, deal	d place, a th occurr	ed at the time, o	date and	d place, an	d due to	the cause(s)
To with	-	29b. Signature and title of certifier	TTGNDIN	G PH	HYSICIA			290	0			te signed (
RO		30. Name and address of person with MUSA MOMO	no completed cause	of death (Item	23a) (Type,	Print)	- AI	/ #3	301,	LAND	OVE	R,	MD	20785
Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Signa		<i>.</i>								

		1 - For State Registrar				and / Dep		t of H	lealth and I Death	Mental Hy			23356	
Physici /Medi		1. Decedent's Name (Fi	a A. B	erry						2. Date of De		Year 2005	3. Time of Death 8:00 _{a M}	
Examir	ner	4a. Facility Name (If not					4b. City,	Town, o	r Location of Death	1	4c. Co	unty of Death		
Funeral	r	Gilchrist I	Hospic er 6.	e Center		rs. last birthday		DWSO 1 Year	n If Under 24 Hrs.	8. Date of Bin	th	Baltin		
Director		119-07-395		1□M 3 {□F	94	Yrs.	Months	Days	Hours Min.	(Month, Da 4/12/1	y, Year)		lace (State or Foreign http) SSia	
yland			c. County		10c.	City, Town or Lo	ocation					1	0d. Inside City Limits	
Ind 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturel", or items 23e or 28e-f show event, the Madical Experiment the notified at	Director	Md.	none	:		Baltim							1 ☑ Yes 2 ☐ No	
with II	Dir	10e. Street and Number					10f. Zip					of What Coun	itry?	
death ms 23	Funeral	509 No	ttingh	12. Was Dece	edent Ever in	U.S. 13.	Was Deced		229 lispanic Origin? (S	pecify Yes or No		JSA Race - Americ	an Indian	
6 after dea or items	Fun	1 Never Married	2 ∑ Married	Armed Fo	rces? 2 🕱 No				lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	1.4.	Black, White,		
Baltimore, Maryland 21215-0036 sernit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygienther if filem 27 is marked other then "naturel", or my injury or other treumatic event, the Medical Example Digg.	ed by	3 ☐ Widowed 4 ☐		If Yes, Giv Year or D	ates:		1 Yes		Specify:			ecify: Whi		
Ind 21215-0 be filed within 72 ho tal Hygiene. d other then "nature event, tra "tealical	Completed	(Specify o		rade completed)	I-40r 5+\	(Give	dent's Usua kind of wor DO NOT us	nk done se retired	lation during most of wor d)	king	16b. Kind	of Business/Ind	dustry	
212 ed wit ygiene tr. tre	Com	,		College (1 5+	-		Artis	st				Art		
and be fill be oth	Be	17. Father's Name (First							18. Mother's Nan			mame)		
iryle should ad Mer marke maric	2	Antony 19a. Informant's Name/	Selezk Belationship			19h Maifi	na Address	/Street	Alexa and Number or Ru	andra K		um State Zie	Code	
Ma nd 2 s alth ar 27 Is		Thomas E.	,			1			am Rd. Ba				C00e)	
or Height		20a. Method of Dispositi				. Place of Dispo cemetery, cre	sition (Nan	ne of		Date		on - City or To	wn, State	
Pag ment ment ent: b		1 □ Burial 2 □ Cr `4 □ Donation 5 □	Other (Spec	ify)	Me		remato		´	6/2005	Cato	nsville	Md.	
Baltimore, Maryland 212's permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If then 27 is marked other then any injury or other treumatic event, If a Magnes.		21. Signature of Funera	Service Dic	ensea	to 1				^{ss of Facility} Hai Columbia				y F.H.Inc.	
		23a. Part1. Enter the di shock, or heart fai	ure. List on	mplications that c ly one cause on e	aused the de	eath. Do not en	ter the mode	e of dyin	g, such as cardiac	or respiratory ar	rest,	c city /	Approximate Interval Between Onset and Death	
Pnysician /Medical		Immediate Cause (Fina disease or condition resulting in death)	2	aE	End		ye /	res	ral d	WEAS	e		menthe	
Examiner	П				or as a cons	equence or):								
E E	iner	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injurthat initiated events	iate	b. Due to (or as a cons	equence of):								
xecute and Il-trans	Examiner	that initiated events resulting in death) Last	1	c. Due to (or as a cons	equence of):								
8760, ate be executed hysician and the burial transit	ical E		Į	500.0 (01 43 4 00113	equence or).								
687 tifficate ng phys as the		IF FEMALE:		u										
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and usage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 \(\text{ Yes}, \text{ outcome of pregnancy} \) 1 \(\text{ Yes}, \text{ outcome of pregnancy} \) 1 \(\text{ Yes}, \text{ outcome of pregnancy} \) 4 \(\text{ Pregnant at time of death} \) 9 \(\text{ Unknown} \) 9 \(\text{ Unknown} \)							,	23d.	23d. Date of delivery Month Day Year			
15, 05, 05 ls, P.C. ls, P.C. ls, P.C. ligned by the detach		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									Be. Did tobacco use contribute to the cause of death?			
O7, US, Cords, wrequires the been signed should be d	ed by	Atrial	+;	brill A	Hior	1				101	/es 2 N	o 3 🗆 Proba	ably 4 DUnknown	
O7, O5. Records, he law requires t e has been signe	Completed	congestive Heart failure									24a. Was an autopsy findings availa prior to completion of cause			
hie. Vital Re uiclen: The l certificate ha											rmed? 2DNo	death? 1 🗌 Yes	•	
of Vita Of Vita Physicien:	9 Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No	medical	Hospital:				Oth	26. Place of Dea				1/	
المناسكية المنا	n: To	27. Manner of Death			npatient 2 of Injury th, Day Year)	ER/Outpatier 28b. Time o		8c. Injun Wor	4 Littlising in	ome 5 Resid		the second secon	1-ospic	
islon (death.	atio	1 Natural 5 2 Accident	Pending investigate		n, Day Year)	Injury	М		k? Yes 2 □ No		. ,			
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Division Division Division To the Hospitel or Attentiviting 4 hours efter death within 24 hours efter death or the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 (Check only one)	Certifying F Medical Exa	aminer: On the ba	best of my k asis of exami ner stated.	nowledge, deat nation and/or in	h occurred a vestigation,	at the tin	ne, date and place, pinion, death occur	and due to the cred at the time,	cause(s) and date and pla	manner as sta ce, and due to	ated. the cause(s)	
To th within To th comp	Me	29b. Signature and title	certifier	1-	1		290.		number		29d. Date sig	gned (Month, L		
		30 Name and address	nthe	my Kl	y, L	116)	Detail		5.205		1-1		2005	
()00		30. Name and address	elx	163	me	6701	1/- (lan	les St.	Balto	. one	212	ox	
s Sta Registr		31. Date filed (Month, D	L 0 6	2005	gistrar's Sig	nature	bart.							

				State of Ma	nyland / De	partment of	Health and	Mental Hy	niene					
			1 - For State Registrar	State of Ma	•	ertificate of		-	Rea. No	000	22257			
			Decedent's Name (First, Middle, Last	st)			Dodin	2. Date of De	ath	000	3. Time of Death			
	Physici /Medic		Margaret Rose B	illig				June 2	8 2	/ Year 2005	5:15 р м			
	Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea	ith	4c.	County of Dea	ath			
			15020 Rolling H 5. Social Security Number 6. S		(In yrs. last birthd	Glenwo		S 9 Date of Bird		Howard	ab all (Gr.). G			
Н	Funeral Director			M 2 X F / . Age	71	Months Days			y, Year) 1 Q		nthplace (State or Foreign ountry)			
	p ,		Usual Residence of Decedent					110 7 30	, 17	55 Nat				
	daryla shov	ō			10c. City, Town or	Glen	wood				10d. Inside City Limits 1 ☐ Yes 2 🔀 No			
	the N	rect	Maryland Howard 10e. Street and Number		15020 RG	10f. Zip Code	Is Drive		10g. Citi	zen of What C				
	filed within 72 hours after death with the Maryland Hygiene. the than "natural", or Items 23a or 28a-f show ent. It's Madical Examinational be motified at	by Funeral Director	15020 Rolling Hil		USA									
	sr dea	uner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 1	Was Decedent of If Yes, specify Cut	Hispanic Origin? (oan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		14. Race - Am Black, Whi				
36	rs afte	oy Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1 ☐ Yes 2 No				Specify:Whi				
Maryland 21215-0036	2 hou atura	ted	15. Decedent's Ed	lucation	16a. De	cedent's Usual Occu	pation		16b. Kind of Business/Industry					
215	ithin 7 18. 18. "In	Completed	(Specify only highest gra	de completed) College (1-4or 5-	+)	ive kind of work done DO NOT use retire	during most of word)	orking						
2	filed w Hygier other th	Cor	12 Homemaker							n Home				
anc	d be fi	o Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid											
ary	2 should be to and Mental it and Mental it is marked or raumatic ever	2	Richard Dominic Pelicano Rocchina Marie Ste											
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event. It is Madical Examinational found by notified at once.		Linda Baumler/daughter 12310 Hungerford Manor Ct. Monr								ovia, MD 21770			
altimore,	Pages 1 nent of Ho int: If iter iry or oth		20a. Method of Disposition 1 Burial 2 Xcremation 3	Removal from State	i .	sposition (Name of crematory or other pla	1	une 30,	20c. Lo	cation - City or	Town, State			
	permit. Pages Department of I Important: If its any injury or o		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Lice)		W. Arur	idel Crema 22. Name and Addr		2005	Oden	ton, Ma	ryland			
Ba	permi Depa Impo any i		1 2000 Un L	To the	MO1251	Going Hom	e Cremat	ion Serv	ice	P.O. E	Box 784 .le, MD 21029			
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not					di KSVII	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition Metastatic Lung Cancer								Onset and Death 1 1/2 years			
h	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):				_					
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	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.										
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Box 6	leath certifica attending ph I for use as t	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy							23d. Date of de	livery			
ğ	death e atte	Physician/Med	in the past 12 months? 1 Ves 2 No. 1 Ves 2 No.								Month Day Year			
P.O.	that the de ted by the a detached f	Phys	9 Unknown	9∐ Unknown										
	ires tha signed d be det	þ								co use contribute to the cause of death? 2 □ No 3 ☑ Probably 4 □ Unknown				
Records,	w require	Completed	24a. Was an								2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available			
Re	The lav	dwo						autop	rmed?	prior to death?	completion of cause of			
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<u>></u>	is di	ို	1 ☐ Yes 2 🛣No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpa	IGHT 3 DOV		Home 5 X Resid	lence 6	Other (Spe	ecify)			
UC C	Attending Physician: r death. scfor: After this certification by the funeral director.	tlon:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury Work? 28b. Injury at 28d. Describe how injury occurred Work?											
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á	tal or	Certification:	4 Homicide determined	building, etc.	(Specify)			City or Tow	m, State)					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exam	ysician: To the best o	examination and/or	eath occurred at the t	ime, date and plac opinion, death occ	e, and due to the durred at the time,	ause(s)	and manner as	s stated. e to the cause(s)			
	o the ithin 2 o the omplet	Med	one) 29b. Signature and title of certifier	and manner stat	ed.	29c. Licen				e signed (Mont				
	⊢ ≯ F 8		houles F	Then of	MD	D591				29, 2				
			30. Name and address of person who	completed cause of de	ath (Item 23a) (Typ	pe, Print)	<u></u>							
			Charles F. Mess, 31. Date filed (Month, Day, Year)			ter Dr. #	100 Colu	mbia, MD	2104	44				
	9"	ite	or, Date filed (Month, Day, Year)	32. Hegistra	r's Signature									

			1 - For State Registrar	State of Marylan	d / Depa		Health and M	ental Hygi	_	E. 20050	
	Physici /Medi		1. Decedent's Name (First, Middle, Las	Buchhol	2		200	2. Date of Death Month	Day / Y	3. Time of Death	
	Examir		4a. Facility Name (If not institution, give	street and number) RCL F the	lake	4b. City, Town, o	Lisbu	F14	4c. County of	Death	
	Funeral Director		5. Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, June 1,	Year)	Birthplace (State or Foreign Country) Maryland	
	Maryland -! show		Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo	cation				10d. Inside City Limits	
2	with the Ma a or 28e-1	Funeral Directo	Maryland Talbot 10e. Street and Number	E	aston	10f. Zip Code		10	g. Citizen of Wha	MXYes 2 No at Country?	
7	death w	ral	7091 Dogwood Terr			2160			US		
980	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan cardment of Heatth and Mental Hygiene, cardment of Heatth and Mental Hygiene, cortent: If item 27 is marked other than "netural; or items 23a or 28e-1 show injury or other treumatic event, the Madical Evantinar must be natified at a injury or other treumatic event, the Madical Evantinar must be natified at a.		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ♥ ivorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 XXo If Yes, Give Year or Dates:	ł	Was Decedent of H f Yes, specify Cub I□Yes 2XXNo	Hispanic Origin? (Spean, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
Maryland 21215-0036	within 72 ho ene. then "netur he Medical	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Deced (Give life.	lent's Usual Occup kind of work done DO NOT use retire	pation during most of working d)	6b. Kind of Busin	ess/Industry		
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and	d be find H	Be	17. Father's Name (First, Middle, Last) Charles Wood Dul:	i m			18. Mother's Name		,		
aryl	2 shout and Me Is mark	2	19a. Informant's Name/Relationship (7		19b. Mailir	g Address (Street	and Number or Rural	Edith E			
	and 2 salth a n 27 ls		Debbie B. Cavalie				Road Cambr	idge, Ma	ryland	21613	
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in the second	Physician /Medical Examiner	e.	23a. Party. Enter the disease, or compands, or heart failure. List only of the compand of the co	DVAFE	respiratory arres	st,	Approximate Interval Between Onset and Death				
68760,	ires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					٠		
.O. Box	the death certifica by the attending ph ached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	Was decedent pregnant n the past 12 months? 1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							
rds, P	w requires that been signed should be det	ed by P	Part II. Other significant conditions or	ontributing to death but not resi	ulting in the ur	iderlying cause giv	en in Part I.	23e. Did toba	40	te to the cause of death? Probably 4 Unknown	
I Records,	The la ate has page 2	Completed by						24a. Was an autopsy performe	prior		
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Haanitalı		0.1	26. Place of Death	(Check only one)			
of	Phys this ral di	. To	1 Yes 22 No 27. Manner of Death	Hospital: 1 npatient 2 28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Injur	4 Nuising Hom	e 5 Residen			
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	he Hospitel or in 24 hours afte he Funerel Dire pletely filled in I	Medical	29a. Certifying Phy (Check only one) Certifying Phy 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tirestigation, in my o	ne, date and place, ar pinion, death occurred	nd due to the cau d at the time, date	se(s) and manne e and place, and	r as stated. due to the cause(s)	
	To the To the Complet	Σ	29b. Signature and title of certifier Cilcuit	D 850	eac	29c. Licens	e number	6 290	d. Date signed (M	fonth, Day, Year)	
			30. Name and andress of person who o	ISANCS		Print) Co	ASTAL LIC, BU	HOST	TOF A	T LAKE	
:	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	land.		-			

		1_ For State	State of	Maryland /						lental Hy	· .			
		Registrar	Certificate of Death							2. Date of De	2005 2		23359	
Physic	ian	1. Decedent's Name (First, Middle, L		Q ALL	11-1	2 – Lu	. [12.4			Month	D	ay	Yeer	3. Time of Death
/Medi			7LYSSA	Bour	1161			Location	of Dooth	JUNE	28	c. County of	25	2:55 P.M
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Funeral		Social Security Number 6.	Sex 7. 1 ☐ M 2 K F	Age (In yrs. last I		ff Under Months	1 Year Days	If Under Hours		8. Date of Bi (Month, Da	av. Year)_	Сои	
Director		NWE	201		Yrs.				Min. 53	6-28	-0	5 1	MAR	RYLAND
and *		Usuel Residence of Decedent 10a. State 10b. County	-	10c. City, To	wn or Lo	cation	-							10d. Inside City Limits
Manyl f sho	ō	Maryland Charle	25	,	V - 1 6	dorf								1 ∰Yes 2 □ No
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with 3e or	ā	2238 Mattawom	an-Beant	own Roa	ad		206	01				USA		,
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be tiled within 72 hours efter death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show many injury or other treumatic event, the Modical Eventual trems to notified at once.	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S.	13.	Was Deced	lent of Hi	ispanic Or	igin? (Sp	ecify Yes or No	0-	14. Race	- Ameri	can Indian,
or Ite	Ē	Never Married 2☐ Married	Armed Force 1 Yes 2 If Yes, Give							Rican, etc.)	1	Black Specify:	, White,	etc.
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Maryland d 2 should be file th and Mental Hy 7 is marked othe treumatic event,	1	19a. Informant's Name/Relationship		1.	9D. Maili	ng Address	(Street a	ana Numbi	er or Hura	i Houte Numb	er, City	or lown, S	itate, Zip	20601
e, N 1 end 1 Health iem 27 other tr		Tiffany I. Bot 20a. Method of Disposition	ivier (M	other)				woma		eantow Date		d Wa ocation - 0		rf, MD
Pages Tent of I		1 Burial A Cremation 3		como	tery, crei	natory or o	ther place	e) arden				dorf,		JWII, State
Baltimore, permit. Pages 1 er Department of Hea Importent: If item any injury or othe		' 4 Donator 5 Dother (Spec 21. Signatur Fu € at Se ✓ Lio		11111		2. Name an		<u>i</u>		-	_			
Balt permit. Departr Imports any inje		Drug A	lu-	M 00173					ED	erwein White	Fun Pls	eral .,MD	Serv 206	rices 595
		23a. Part . Enter the disease, or co	mplications that cau	sed the death. Do										Approximate Interval Between
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/Medical		resulting in death)	Due to (pr	as a consequenc	e of):									
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cate physisthe	dical	`	d											
I Records, P.O. Box 6 The law requires that the death certifi ate has been signed by the attending t page 2 should be detached for use as	/Me	IF FEMALE:	23c. If yes, outco	me of pregnancy								23d. Date	of dollar	201
Geath cere attendir	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birti	n 2 □ Fetat dea It at time of death		Ectopic production of the control of						Mont		Day Year
the d y the	iysi	1 □ Yes 2 □ No. 9 □ Unknown	9□Unknow											
that	by Pł	Part II. Other significant conditions	contributing to deal	h but not resulting	j in the u	nderlying ca	ause give	n in Part I		23e. Did 1	tobacco	use contrit	oute to the	ne cause of death?
rds quires n sign	g									10	Yes 2	2□No 3	B 🗌 Prob	ably 4 Dunknown
cord w requir s been si	Completed									24a. Was	an	24b. W	ere auto	psy findings available
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of Vita Physicien: rthis certifica ral director, r	o Be	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inp	atient 2 ER/0	Outnatier	nt 3□ DO	A Othe			me 5 ☐ Resi		6 □Other	(Specif	(v)
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Division of Vital Records, or Attanding Physicien: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be or	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 200. Flace of	Injury - At home, etc. (Specify)	farm, str	eet, factory	, office			28f. Location (City or To			r or Rura	l Route Number,
Distance and the control of the cont	Certification:		Donaing	, 6.6. (5,550.1)										
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omple	Me	29b. Signature and title of cartifier	0 11	1/-	-	29c	. License	number			29d. Da	ate signed	(Month,	Day, Year)
F- 5 F- 0		Erne de:	to lo	00,0	W 6	S D	22	190		'	GM	we 2	81:	2005
(30. Name and address of person wh	o completed cause	of death (Item 23a							1			
12		ERNESTO A. GA		7503			TIS	RD.	CL	INTON	m	D. 2	073	35.
Sta	ate	31. Date filed (Month, Day, Year)		istrar's Signature	4	book	,	-						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					arylaria /	•		of Death	Wientaning	Reg. No	05	23360		
	Physici	an	1. Decedent's Name (First, Middle, Las	•					2. Dete of De	eeth		3. Time of Death		
	Physici /Medic	al watter w. Burkett								12, Dey 200	5	0320 AM		
	Examin	er	4e Facility Name (If not institution, give			0 6		4b. City, Town, or						
9			Allegany County					Cumberla			egany			
	Funeral Director		101 12 0001		e (In yrs. last		If Under 1 Ye Months Da			rth ay, Year) -1910	9. Birthpla Country PA	ce (State or Foreign v)		
	and *	ł	Usual Residence of Decedent 10a. State 10b. County			100	f. Inside City Limits							
	4 sho	5	PA Bedford				100	1XXYes 2□No						
	28s	20	10e. Street end Number		Hyndm	00,5	10f. Zip Cod	Ð		10g. Citizen of	What Countr	u?		
	23e o	a D	132 Water Street		USA		, .							
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours aftar deeth with the Maryland Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Maritel Status 1 Never Merried 2 Married 3 Wildowed 4 Divorced	12. Wes Decedent Armed Forces? 1 ☐ Yes 2 X X If Yes, Give Year or Dates:		as Decedent os, specify C		spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White						
5	"natu	ete	15. Decedent's Edu (Specify only highest grad	cation le completed)	16	(Give kir	nt's Usual Oc and of work do	ne during most of wa	rking	16b. Kind of B	usiness/Indu	stry		
12	withir	E	Elementary/Secondary (0-12)	College (1-4or 5	i+) c	ignali	NOT use re	tired)		Railr	and			
d 2	Hygie Hygie Iffer		17. Father's Neme (First, Middle, Last)		3	cynac		18 Mother's Na	me (First, Middle					
an	d be ental	To Be	Marion (mnu) Bur	bott					eca Hill		116)			
37	d 2 should be filed within th and Mental Hygiena. 7 is marked other than "fraumatic event, the Mec	-	19a. Informant's Name/Relationship (T)		1:	9b. Meiling	Address (Str	eet and Number or R			State Zin C	ode)		
Ž	alth a 27 ta r trai	- 1	Robert Burbett.	son				8. Hyndmai			,,, -	/		
ore,	of Har	- 1	20a. Method of Disposition		ocation - City or Town, State									
E	Pege Int: If		1√ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	7-16-05	-16-05 Buffalo Mills, PA								
Balt	permit. Peges 1 Department of H Important: If the any Injury or ot		21. Signature of Funeral Service Licens	80				dress of Facility						
ш	ýO E # 9		De	A/		На	rvey H	. Zeigler	tuneral	Home,	Hyndma	n, PA		
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or compishook or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	. CORO		AR	TERY	DISEA				iterval Between Inset and Death		
Box 68760,	rtificate be ng physicla s as the bur	in/Medicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest	c	Due to (or as		,							
	death e afte ed for	Sicia	Part II. Other significant conditions cor	ntributing to death bu	ut not resulting	in the unde	erlying cause	given in Part I	23h Did	23b. Did tobacco use contribute to the cause of deeth?				
9. P.O		by Physician/					.,	g., o.,	10	9 40.		oly 4 □ Unknown		
of Vital Records,	The law requiras ata has been sig pega 2 should b	Completed b							24a. Was	en autopsy ermed?	availa	autopsy findings able prior to eletion of cause eth?		
alF	: The la								10	Yes 25 No	101	∕es 2□ No		
Zi.	sician: The	Be	25. Was case referred to medical examiner?	Hospital:					eth (Check only o	one)				
ō	Phys this ral di	2	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 LI Inpatie		Dutpatient Time of	3LI DUA		lome 5 ☐ Resi					
Division	Attending I or death. ector: After by the funer	Certification:	1 万Naturel 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No						28d. Describe how injury occurred				
Ω			4 Homicide determined		Se. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)					Street and Numb vn, State)	oer or Rural R	loute Number,		
	he Hospital in 24 hours he Funeral ipletaly filled	edicai	29a. Certifier (Check only one) 1 ☑ Certifying Physical Examination	nician: To the best of ner: On the basis of and manner sta	examination a	ge, death oo and/or inves	ccurred at the tigation, in m	time, date and place y opinion, death occu	, and due to the rred at the time,	cause(s) and made and place,	anner as state and due to th	ed. e cause(s)		
	within 2 To the	∑	29b. Signature and title of certifier	0/	4			ense number		29d. Date signe		y, Year)		
	6		1 Holoustrems	1. Dane	41_		10.	-14861		JULY	137	2005		
	NLS		30. Name end address of person who								*			
	Stat	e	Robustiano J. Bar 31. Dete filed (Month Day, Yaar) 2005	Registre	orial F or's Signature	ospit	al Med	ical Bldg	, Cumber	land, M	D 215	02		
	Registra	ar	JUL 1 4 ZUUS	Degene.	J.	Sept.								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** Britt Otis Wayne 2005 10:45 A JULY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. Hours Min. 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 X M 2 □ F Yrs. 83 Director 215-14-6288 Maryland Usual Residence of Deceden with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a Stale or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No LaVale Completed by Funeral Director Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itams 23a 7 Cash Valley Road 21502 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If liem 27 is marked other than "natural", or itama 23, marry or other traumatic event, its Medical Exemine many or other traumatic event, its Medical Exemine man 12. Was Decedent Ever in U.S. Armed Forces? 1 [2]Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify 3 Midowed 4 □ Divorced White 16a. Decedeni's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondary (0-12) College (1-4or 5+) 10 Laborer Tire and Rubber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Joyce Britt Carrie Catherine Durst ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Cash Valley Road, LaVale, Maryland 21502 Linda Winebrenner / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removat from State Department of important: If any injury or once. * 4 □Donation 5 □ Other (Specify) 07/15/2005 Zion Memorial Park Cumberland, Maryland 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Furerat Service Licensee 404 Decatur Street, Cumberland, Maryland Approximate interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final **Physician** disease or condition resulting in death) Congestive Heart Failure /Medical Due to (or as a consequence of) **Examiner** Chronic Obstructive Pulmonary Disease Exacerbation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Cardio Pulmonary Arrest that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of detivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate 1 Yes 2E No Division of Vital or Attending Physician: Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 7 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 1 ENaturat 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, streel, tactory, office building, etc. (Specify) 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier JULY 13 2005 D0062429 UA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nLA 500 MEMORIAL AVENUE SUITE 105 CUMBERLAND, MARYLAND DR.AQEEL SALEEM 31. Date filed (Month, Day, Year)

JUL 1 4 2005 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland	-	artment of H			giene	20000
	Physici /Medic		1. Decedent's Name (First, Middle, Last THOMAS EDWAR					2. Date of Dea Month	Day Ye	M
	Examin		4a. Facility Name (If not institution, give 17102 HORSEHE	street and number)		4b. City, Town, or BADEN	Location of De		4c. County of E	
£	Funeral Director		5. Social Security Number 6. Se 218-05-7797		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Birth (Month, Day	h y, Year) 9.	Birthplace (State or Foreign Country)
	show	5	Usual Residence of Decedent 10a. State 10b. County		Town or Lo	ecation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the M s or 28a-f	Dire	MARYLAND PRINCE 10e. Street and Number	GEORGE' S B	BADEN	10f. Zip Code			10g. Citizen of Wha	
36	72 hours after death with the Maryland natural; or Items 23s or 28s-f show deal Examinat must be Indillish ui	by Funerai	17102 HORSEHEAD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	ROAD 12. Was Decedent Ever in U.S Armed Forces? ☼™es 2 □ No If Yes, Give Year or Dates: WWII		206] Was Decedent of Hi If Yes, specify Cuba 1□Yes 2[X]No		? (Specify Yes or No- uerto Rican, etc.)	U.S. 14. Race - A Black, V Specify:	A. American Indian, White, etc. WHITE
21215-0036	c * 6	Completed I	15, Decedent's Edi (Specify only highest grad	ucation	16a. Decer (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	turing most of	working	16b. Kind of Busine	
Maryland 2	be filed stat Hygi od other event, I	To Be Co	11 17. Father's Name (First, Middle, Last) THOMAS BRYAN		PAL	NTER		Name (First, Middle,		OMMUNICATION
	1 and Health em 27 other tr		19a. Informant's Name/Relationship (T) ELSIE BRYAN-WI 20a. Method of Disposition	FE 20b. Pla	1710	2 HORSEH	IEAD R	Paral Route Number D., BADE		20613
Baltimore,	permit. Pages Department of Important: If it any injury or o		XIXBurial 2 ☐ Cremation 3 ☐ I `4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens	ST.	PET:	matory or other place ERS CEME 2. Name and Addres RAYMOND	ETERY	7-6-05 AL SERVI		,MARYLAND
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only disease or condition resulting in death)	ilications that caused the death.	Do not ent		g, such as care			Approximate Interval Batween Onset and Death
8760,	sate be executed hysician and the burial-transit	licai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence. Due to (or as a consequence.) Due to (or as a consequence.)						
O. Box 6	The law requires that the death certificate be executed the ras been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
rds, P	quires that in signed b uld be deta	by	Part II. Other significant conditions con	entributing to death but not result	-	nderlying cause give	en in Part I.			te to the cause of death? □Probably 4 □Unknown
Record		Completed	CHRONIC OB	structure L	NG	DISTA	£	24a. Was autop perfor 1 Yes	rmed? prior deat	re autopsy findings available r to completion of cause of th? Yes 22 No
of Vital	Physician: The tribic certificate harral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death		ER/Outpatier		er: 4 🗌 Nursir	Death (Check only or ng Home 5 Resid		Specify)
Division	I or Attending Ph after death. Director: After th i in by the funeral	Certification;	1 Datural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year)	Injury me, farm, sti		<br Yes 2 □ No	28f. Location (S City or Tow		or Rural Route Number,
	Hospital 4 hours a Funeral I ely filled	edicai Ce	29a. Certifier 1 To Certifying Phy (Check only one)	/sician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, deat ion and/or in	h occurred at the time vestigation, in my op-	ne, date and pi pinion, death o	lace, and due to the occurred at the time, o	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	allu Illaliioi Slatou.		29c. License	number	7-9	29d. Date signed (M	fonth, Day, Year)
	141	0	Name and address of person who a	A comment of	23a) (Type, BE	Print)	Mr	203	704	
	Sta Regist		31 Date filed (Month_Day, Year)	32. Registrar's Signat	ure	Section 1	1			

			For State Registrar	State of N	Maryland		artment o			ind M		giene Reg. 2	A 400	2	23363
			1. Decedent's Name (First, Middle	Last)							2. Date of De	ath Da	y Ye	ar	3. Time of Death
	Physici /Medio		Constance	Α	Burns								2005		9:38 P M
	Examir		4a. Facility Name (If not institution	give street and number	r)		4b. City, To	wn, or L	ocation o	f Death		40	. County of C	eath	
			5709 Dun Horse				Derw						Montg		
	Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Months 0	Year Days	If Under a	Min.	8. Date of Bir (Month, Da	y, Year,)	Count	ace (State or Foreign ry)
	Director		224-44-9898		67	Trs.					July 1	.6 1	937	V	irginia
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation							10	d. Inside City Limits
	daryl f sho	ō	Md. Mc	ntgomery		Derv	vood								1 ☐ Yes 2 🛣 No
	the 1	ect	10e. Street and Number				10f. Zip C	ode				10g. Ci	tizen of Wha	Count	ry?
	3a or	Funeral Director	5709 Dun Horse	Lane					208	55		Uı	nited	Sta	tes
	me 2	era	11. Marital Status	12. Was Deceder	nt Ever in U.S	S. 13.	Was Deceder	t of His	panic Orig	gin? (Spe	ecify Yes or No Rican, etc.))-	14. Race - /		
9	or Ite		1 ☐ Never Married 2 Marri	Armed Forces ed 1 Tyes 2 Filt Yes, Give		1	ii Yes, specily 1 ⊟ Yes 2É		Specify:	, Fuerto	nicari, etc.)	1	Black, V		nite
8	72 hours after death with the Maryland natural', or Items 23s or 28s-f show disal Examena invalor Indiffed at	d b	3 Widowed 4 Divorced	Year or Dates	S:		103 22	3 140	Зреспу.				Specify:		
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2	filed v Hygie other t		12 17. Father's Name (First, Middle,			11011	lemaker		18 Mothe	r's Name	(First, Middle				
Maryland 21215-0036	2 should be filed withir and Mental Hygiene, Is marked other than aumatic event, IteM	Be	William Gatt								inia		senber	g	
2	should nd Men marke umatic	은	19a. Informant's Name/Relations	nip (Tvoe, Print)		19b. Maili	na Address (S	Street ar	nd Numbe	r or Rura	I Route Numb	er. City	or Town, Sta	e. Zip	Code)
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury ago, there is marked other than "natural", or Items 23s or 20s-f show any injury ago, the traumatic event, the Medical Exametric must be notified at once.		David W. Burns	/ Husband		5709	Dun F	lors	e La	ne,	Derwood	l, Me	d. 20	855	
ē,	Health tem 27		20a. Method of Disposition			ace of Dispo	osition (Name	of ar place	1		Date	20c. L	ocation - City	or Tov	vn, State
E O	Pages nent of l		1 ☐ Burial 2 🗖 Cremation 4 ☐ Donation 5 ☐ Other (S)		te		Litan (1	7/1	/05	A.	lexand	ria	, Va.
Baltimore,	permit. Pag Department Important: I any injury once.		21. Signature of Funeral Service		1		2. Name and	Address	of Facilit	v					•
Ö	Depar Impor any in		Murrel	W. Ba	rker						Funera Laytor			đ.	20882
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the death	. Do not en	ter the mode of	of dying	such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between
	Pnysician	S 11	Immediate Cause (Final disease or condition		UNG CA	NCER									Onset and Death 8 Months
	/Medical		resulting in death)	Due to (or a	as a consequ	uence of):									
	Examiner		Sequentially list conditions	b											
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cit sase of injury	Due to (or a	as a consequ	ence of):									
	ecute and trans	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ioneo of):		_						-	
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transitions.	E		000 10 (01 1	as a consequ	191109 01).									
87	physics the l	dical		d											
9 X	leath certifica attending ph	Physician/Me	IF FEMALE:	23c. If yes, outcom	ne of pregnar	ncy							23d. Date of	deliver	v
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕅 No	1 ☐ Live birth 4 ☐ Pregnant	2 🗆 Fetal	death 3	☐Ectopic preg☐ Other (spec						Month		Day Year
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٣.	s that ned b e deta	by PI	Part II. Other significant condition	ns contributing to death	but not resu	ulting in the u	inderlying cau	se giver	n in Part I.		23e. Dîd t	obacco	use contribu	e to the	cause of death?
Records,	quires in signe										1 🔀	Yes 2	□ No 3] Proba	bly 4 □Unknown
000	law requast been 2 should	Completed									24a. Was		24b. Wer	autop	sy findings available
æ	The lav te has	E O									auto perfo	psy ormed? 2□XNo	deat	h? Yes	pletion of cause of
Vital		a)	25. Was case referred to medical						26. Place	of Death	(Check only				
f V	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2X☐ No	Hospital: 1 ☐ Inpa	atient 2 🗆 E	ER/Outpatie	nt 3 DOA	Other	4 🗆 Nu	rsing Ho	me 5 Resi	dence	6 Other (Specify	
n of			27. Manner of Death 1 X Natural 5 Pendin	28a. Date of in (Month, i	njury Da <i>y</i> Yea <i>r</i>)	28b. Time of Injury	f 28c	. Injury Work	at ?		28d. Describe	how inju	ry occurred		
Ö	Attending r death. ector: After oy the fune	atic	2 Accident investig	ation			М		es 2 🗆 i						
Division	f or Attencater death Director:	Certification;	3 Suicide 6 Could in determined		Injury - At ho etc. (Specify	me, farm, st	reet, factory, o	office			28f. Location (City or To	Street a. wn. Stat	nd Number o e)	r Rural	Route Number,
	urs af urs af iral D														
	To the Hospital or Attenwihin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the be Examiner: On the basis	of examinat	wledge, deat tion and/or in	n occurred at ivestigation, ir	the time my opi	e, date an nion, dea	a place, th occurr	and due to the ed at the time,	date an) and manne d place, and	r as sta due to	ited. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifie	and manner	Stated.		29c. I	icense	number		- T	29d. Da	ate signed (N	onth, E	Pav. Year)
N.	F 3 F 8		10	(1) by	M				-1856	51			JUNE		
	5		30. Name and address of person	was completed causes	death (Item	23a) (Type	Print)								
			DAVID J. PERRY	_			ST.,	N.W	., 1	WASH:	INGTON,	D.0	c. 20	010	
	St	ate	31. Date filed (Month, Day, Year)	•											
	Regist		JUN 3 0	2005	strar's Signa	1 19	1000								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item//, perith, 345, 7/19/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY Dav **Physician** 05, 2005 7:00 PM HELEN RICHARDS BROADWATER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Frostburg Village Nursing Center Frostburg If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 1 F Director May 5, 1929 Maryland 213-24-7110 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, Ite Medical Examinar must be routilled at Yes 2 □ No Frostburg Director MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532 USA 100 Honeysuckle Lane, Apt. 310 Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, GiveX Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify: White Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Self-employed 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personal Care Home Personal Home Care Provider 12 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Pagas 1 and 2 should be finent of Health and Mental Fant: If item 27 is marked of Florence Emma Snelson John William Richards, Sr. 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12609 Winchester Road, SW, Cumberland, MD 21502 Eric Broadwater, Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Rurial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important: If any injury or once. New Germany Methodist, Jul 8,2005 Grantsville, MD 4 Donation 5 Other (Specify) 21. Signature of Fundal Service 22. Name and Address of Facility Newman Funeral Homes, P.A. Humas 179 Miller St, POBox 275, Grantsville, MD 21536 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Cerema interzetter /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death cartificate ba exacuted burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the. attending IF FEMALE usa 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day jo 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown neumonia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 Yes 1 Yes 2 No Hospital or Attending Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ woweller 0055325 July 06, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 TOURN SHI Temace WOIVSOCK

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>05</u> **Physician** JÜNE 23, 8:01 P M India L. Carpenter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 11700 OLD COLUMBIA PIKE MONTGOMERY CO SILVER SPRING If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Jan. 9, 2 Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2X□ F Director 218-59-5141 Yrs. 2001 Washington, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ral', or Itams 23a or 28a-f shov Examiner must be notilied at Director Maryland Montgomery Silver Spring 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11700 Old Columbia Pike #1005 20904 United States Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is markad other than "natural", or Ital 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Puerto Rican Specify: Black 3 ☐ Widowed 4 ☐ Divorced traumatic avant, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Student School - Pre K 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Hugo Carpenter, Jr. Nicola Claggett ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 11700 Old Columbia Pike # 1005, Silver Spring, MD James Hugo Carpenter, Jr. injury compar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ¹ 4 □ Donation 5 □ Other (Specify) Mt. Olivet Cemetery 7/1/05 Washington, D.C. 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service License e 7400 Georgia Ave. N.W., Wash. D.C. na 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple **Physician** mouries disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2□ No 24a. Was an certificate has autopsy performed? 1 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 MOther (Specify) SCENE this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending Natural subject dell from 9th floor apartment 1 ☐ Yes 2 No 2 Accident investigation 6-23-05 after death 7:53 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11700 810 Columb filled in by 4 Homicide 11700 old Columbia At home Pike Silver Spring mb

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) OCME JUNE 24, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Penn Street Baltimore, Maryland 21201 LING

Registrar

31. Date filed (Month, Day, Year) 01 2005 32 Registrar's Signature

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	Physicial		1. Decedent's Name (First, Middle, Last)					2. Date of Death		G. Time of Death
	Physici /Medio		Bruce C. Chambe					June :	25 ^{ay} 2005	1330 м
4	Examir	ner	4a. Facility Name (If not institution, give	,		-	or Location of Death		4c. County of Death	
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	Funeral Director		5. Social Security Number 214-40-1744 Usual Residence of Decedent	M/M 2□ F	s. last birthday) 62 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1uly 27		place (State or Foreign ntry) yland
	/land		10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
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	3a or 28	i Dire	10e. Street and Number 1205 Springwood	Ct.		10f. Zip Code 2 1 0 1	. 2	10	g. Citizen of What Cou	ntry?
936	within 72 hours after death with the Maryland ene. than "neturel", or Items 23s or 28e-1 show ta Modical Examiner must be multied at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cul	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: B1	etc.
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Maryland 21215-0036	ked b	To Be	James C. Chambe				Bernice	Brooks	5	
	is 1 and 2 shou of Health and M item 27 is mar other traumati		19a. Informant's Name/Relationship (Ty Barbara O. Cham	bers(Wife)	1205	Spring	wood Ct.	Arnolo	City or Town, State, Zij	012
ore	8 5 = 0		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ R	emoval from State M		ration (Name of	ada)		0c. Location - City or T	
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u C	ng fter inei	ion	Matural 5 ☐ Pending	(Month, Day Year)	Injury		rk?]Yes 2∐No	28d. Describe hov	vinjury occurred	
Division	or Attending after death. Director: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre city)			28f. Location (Stre City or Town,	eet and Number or Rura State)	I Route Number,
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	Physic	ian	Decedent's Name (First, Middle, Last, Patricia Ann Cont						June 27	2005 Ye	ar 4 30 mg
	/Medi Examii		4a. Facility Name (If not institution, give a 9617 Garris Shop I	street and number)			4b. City, Town, o	r Location of Death		4c. County of D	4:30 PM beath ton County
	Funeral Director		5. Social Security Number 6. Set 192–30–0163	IM 2TVF	e (In yrs. I 56	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 26	Year) 9.	Birthplace (State or Foreign Country) Pennsylvania
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9600	172 hours after death with the Marylar "natural", or Items 23a or 28a-f show idical Examiliar II wat by mullifud at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:			Vas Decedent of H i Yes, specify Cuba	ispanic Origin? (Sp nn, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - A	merican Indian, /hite, etc. White
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Mar	id 2 sh Ith and Ith and Ith am Ithaum		19a. Informant's Name/Relationship (Ty) Philip S. Conti /					and Number or Rur			e, Zip Code) Land 21740
Baltimore,	Page ent o nt: If ry or		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)			ace of Dispo	sition (Name of natory or other place	Θ)	Date 2	0c. Location - City	
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1-	5		Hind Hamde	in, MD	: 113	20 0	IDAC	CT. H	agenst	own, Mi	0 21440
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State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** June 26, 2005 Coy Lee Cooper 4:21 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Center Prince Georges Cheverly If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeal 940 **Funeral** Birthplace (State or Foreign Country) Days Hours 1**X** M 2□ F 64 Yrs. Director 238-64-5840 North Carolina Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h Count 10d. Inside City Limits rel', or Items 23e or 28e-f show Exerciner must be notified at Director Maryland Prince Georges Capitol Heights 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6811 Jade Court 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. d 2 should be filed within 72 hours after of th and Mental Hygiene.
7 Is marked other then "naturel", or Iter traumatic event, the Medical Enerther 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Capital Essex Partners Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Maintenance Engineer Maintenance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Artis Cooper Eva ျှ Strickland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is rr any injury or other traum once. Velma Sessoms Cooper (Wife) 6811 Jade Court; Capitol Heights, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State July 1,2005 Spring Hope; Nash County 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Strickland Family Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) North Carolina 21. Signature of Funeral Service Licenses W. Wesley Chavis III Funeral Services, Inc. 1722 North Capitol Street, N.W.; Wash.D.C. 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myocardial Infarction disease or condition resulting in death) Immediate /Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease 21 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Diabetes Mellitus 23 years Due to (or as a consequence of): the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown ģ signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. Hypertension Be Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 █ DOA 1 ☐ Yes 2X No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the and pranner stated. Certifie Medical completely (Check only one) in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29 29d. Date signed (Month, Day, Year) 0 29d License number 09117 ress of pe who come ted cause of # ath (Ite 30. WASHINGTON DC STREET VARNUM 1160 2. Registrar's Signature 31. Date filed (Month, Day, Year) State blesin & Sports Registrar

State of Maryland / Department of Health and Mental Hygiene

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			Decedent's Name (First, Middle, La	st)	_				2. Dete of Dea		05 24	Bed Deth
	Physici		SOOK JA CH	OI					JUNE	27, 20	Year 05 5	10PM
	/Medic Examin		4a Fecility Name (If not institution, given	re street end number)				4b. City, Town, or	Location of Deeth	4c. County	of Deeth	
			RANDOLPH HIL	L NURSING	HOM			WHEATC		MON	TGOMERY	
•	Funeral Director		229 57 2683	Sex 7. Age I□M 2□√F	(In yrs. lest		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, De DEC.	7, 191	9. Birthplace (S Country) 7 S . I	itete or Foreign KOREA
	and **		Usuel Residence of Decedent 10a. State 10b. County	1	10c. City, To	own or Loca	ition				10d. lns	ide City Limits
	ath with the Marylar 123s or 28s-f show	ō	MD MONTGO	OMERY	STI	VER	SPRIN	G			15	Yes 2□No
	r 28s	Funeral Director	10e. Street end Number				10f. Zip Code			10g. Citizen of V	Whet Country?	
	th wit	aiD	440 UNIVERSIT	Y BLVD			2203	0		KORE	A	
	Hems Hems	ne	11. Maritel Status	12. Was Decedent E Armed Forces?		13. Wa	as Decedent of h	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Rao Blac	e - American Indi ck, White, etc.	an,
Maryland 21215-0020	a SE	ρλ	1 ☐ Never Married 2 ☐ Married 3 █ Widowed 4 ☐ Divorced	1 □ Yes 2□ N If Yes, Give X Year or Dates:			Yes 2□ No			Specify	ASIAN	1
5-	be filed within 72 hours itel Hygiene. d other than "naturel", event, the Medical Exp	Completed	15. Decedent's E (Specify only highest gro	ducetion ede completed)	1	(Give kil	nt's Usual Occup ind of work done O NOT use retire	during most of wo	rking	16b. Kind of Bu	usiness/Industry	
12	within than	du	Elementery/Secondary (0-12)	College (1-4or 5-	+)		EWIFE	0)		PRIV	ላጥE	
0	other of	ပ္	17. Father's Name (First, Middle, Last)		11000		18. Mother's Na	me (First, Middle,			
lan		o Be	H. S. PARK					S. J	. KIM			
ary	shou and M	۲	19a. Informant's Name/Relationship	Type, Print)	1	19b. Mailing	Address (Street	and Number or R	urel Route Numbe	er, City or Town,	Stete, Zip Code)	
	s 1 end 2 should f Heelth end Mar ftem 27 is marks other traumatic		MYONG SOOK BA	ICK (DAUG				RMICK F			LEY MD	
ore	igas 1 e it of Hee if frem or othe		20a. Method of Disposition Y☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	ceme	etery, crema	tion (Name of story or other pla		Date		City or Town, Sta	
Ë			4 ☐ Donetion 5 ☐ Other (Speci	(4)	NORE	BECK		IAL PAR	K 6/29	/05 (OLNEY ,	MD
Baltimore,	permit. Pe Depertman Important: any injury		21. Signature of Funeral Service Lice	see		22.1	Name and Addre	ess of Facility CH	ARLES I	HINDS I	FUNERAI	SVC.
l	40264		THE CIN	77				YAK DR				
			23a. Pert1. Enter the diseese, or conshock, or heart tailure. List only	iplicat ion s that caused one cause on eech lin	the death. (e.	Do not enter	the mode of dy	ng, such as cardia	c or respiratory ai	rest,	Interv	ximate al Between t and Death
els	Physician /Medical		Immediate Ceuse (Final	D.								
	Examiner		disease or condition resulting in death)	e. PNEUMO	NIA Due to (or es	a conseque	ance oi).				1	
		ne			00000	7 a 00/100qa	51100 017.				i	
	ficate be axecuted g physician end as the bunal-transit	Examiner	Sequentially list conditions,	b	Due to (or es	a conseque	ence of):					
68760,	be axe	E	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury	C								
387	g physias the	edical	that initiated events resulting in death) Last	C	Due to (or as	e conseque	ence of):				1	
Box (d								
	that the death certed by the attendined by the attendined for use	Physician/M	Part II. Other significant conditions	contributing to deeth bu	t not resultin	a in the und	leriving cause gir	ven in Part I.	23b. Did	obacco use co	ntribute to the c	ause of death?
P.0	by the	hys					, ,		10	Yes 2 No	3 Probably	4 ₹ Unknown
	o 5 8	by	DIABETES MEI	LLITUS T	YPE							
Records,	v require been sig	g								an eutopsy rmed?	24b. Were aut available completion	
ec	S S	Completed								37	of deeth?	
	Pa at a								10'		1 ☐ Yes	2 No
Vital	Physician: The this certificata rel director, par	o Be	25. Was case referred to medical examiner?	Hospital:		/O . A A A	all DOA Ot	ner:	ath <i>(Check only c</i> Ho <i>m</i> e 5 ☐ Resid		or (Cassiful	
ō	Phys r this srel d	-	1 Yes 2 XNo 27. Menner of Death	28a. Date of Injur (Month, Dey	nt 2 ER	b. Time of	28c. Inju			now injury occur		
lon	Attending Is r death. octor: After by the funer	atlor	1 Naturel 5 ☐ Pending 2 ☐ Accident investigation		Year)	Injury		Yes 2 No				
Division	or Attendatatar deat Director:	Certification:	3 Suicide 6 Could not to determined	28e. Place of Inju	ry - At home	, farm, stree	et, factory, office		28f. Location (: City or Tox	Street and Numb	per or Rural Route	e Number,
Ö	rs after or all Dir											
	To the Hospital or Atte within 24 hours after de To the Funeral Directo complately filled in by th	edicai	(Check only 2 Medical Exa	nysician: To the best o	examination	dge, death o end/or inve	occurred at the ti estigation, in my	<i>m</i> e, date end place opinion, death occ	e, and due to the urred at the time,	ceuse(s) and ma dete and place,	anner as stated. and due to the ca	ause(s)
	To the within 2 To the compla	Med	29b. Signature end title of certifier	and manner sta	Teu.		29c. Licen	se nu <i>m</i> ber		29d. Date signe	d (Month, Dey, Y	'ear)
	F \$ F 8		· NO I	0 -	1/1	sell.	DE	2261		6/28	2/05	
	. A TI		30. Name and eddress of person who	completed cause of de	atn (Item 23	Be) (Type, Pi		<i>⊷ ⊷</i> ∪ ⊥		0/20	703	
	CAC	/		MD , (1\$1		/		ILVER S	PRING N	1D 209	06	
	• Sta	5	31. Date filed (Month, Day, Year)	Registre	r's Signeture	_						
	Registi	rar	JUN 3 0 200	5 Seem	#	Charles .						

DHMH 16 Rev 6/95

			for State Registrar		State of	Maryla	nd / Depa	artmen <i>rtificat</i>			and M	lental H		000	F	00070
	g		Decedent's Nam	e (First, Middle, L	ast)				COIL	Jean		2. Date of D	Reg. N	200	5	233 / U
п	Physic		CHARLES	EDWIN	CLARK							Month	D	^{ay} 2005	Year	1.0 - 0.0 - 7 M
	/Medi Exami		4a. Facility Name (I	f not institution, g	ive street and numb	er)				Location of	of Death	0011		c. County of	f Death	
	Funeral		5. Social Security N			Age (In vr	s. last birthday)	If Under		If Under:	24 Hrs.	8. Date of B				
b	Director		214-28- Usual Residence of	8975	1 X M 2□F	95	Yrs.	Months	Days	Hours	Min.	FEB 6	19 19	10	Cot	place (State or Foreign intry) NJ
	land bw		10a. State	10b. County		10c. C	City, Town or Lo	cation								10d. Inside City Limits
	the Marylan 28a-1 show	octor	MD	MONTGO	MERY	G	ERMANT	'OWN								1 □ Yes 2 No
	ath with the 23a or 2	Funeral Director	10e. Street and Nur 15215 S	nber ENECA F	ROAD			10f. Zip 20	874				10g. C	itizen of W US		intry?
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. itiam 27 Is marked othar than "natural", or Itams 23a or 28a-1 show othar traumatic avant, Itu Medical Exdriner must be notified at	þ	11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed	ed 2 Married	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	No No	1	Was Deced f Yes, spec 1 ☐ Yes	. 6	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	0-		, White	ican Indian, , etc. IITE
15-0	iln 72 h n *natu	Completed		15. Decedent's 8	rade completed)		16a. Deced (Give life. I	dent's Usua kind of wor DO NOT us	k done d	urina most	of worki	ng	16b. I	Kind of Bus	iness/li	ndustry
212	filed within Hygiene. othar than ant, Itte Ma	E O	Elementary/Seco	ndary (0-12)	College (1-4 4	or 5+)	MASTE				AN/F	ARMER	S	ELF	EMP	LOYED
Maryland 21215-0036	should be filled and Montal Hygie marked othar imatic avant, I	To Be C	17. Father's Name (TALIAF)	First, Middle, Las ERRO CL								First, Middle)	
	1 and 2 should the Health and Meniam 27 is marken than traumatic		19a. Informant's Na MARY MAI			AN	19b. Mailin	g Address 9 SE	(Street a	nd Numbe	r or Rura	I Route Numb	oer, City	or Town, S	tate, Zi	0 6 7 4
altimore,	Pages 1 a nent of Hea int: If itam iry or otha	9	20a. Method of Disp 1 Burial 2	☐Cremation 3 (☐Removal from Sta	te DAI	Place of Dispos	sition (Nam patony or oi	ne of	a)	D)ate	20c. L	ocation - C	ity or T	own, State
Baltin	permit. Pages 1 Department of H Important: If ital any injury or oth		21. Signature of Fu	5 ☐ Other (Spec		PRI	ESBYTE:	. Name and	d Address	s of Facility	,				SBU	RG, MD
	G D ≥ a d		/WI	1400	/		P	.0.	BOX	86,	BAR	OME NESVI	LLE	_ MD		
	Physician		Immediate Cause (disease or condition	tialiure. Listioniy Final	one cause on each	ı line.	th. Do not ente	er the mode	or dying	, such as o	cardiac o	r respiratory a	irrest,	•		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	(as a conse	quence of):									
	ed sit	iner	if any, leading to im cause. Enter Under Cause (Disease or i	mediate	U.		quence of):									
,00	icate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) L		c. Due to (or	as a conse	quence of):									
8760,	cate b	dlcal		•	d											
. Box 6	death certif e attending ad for use a	Physiclan/Me	IF FEMALE: 23b. Was decedent in the past 12: 1 Yes 2 9 Unknown	months?	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Fet	aldeath 3 🗌	Ectopic pre Other (spe						23d. Date Month		ery Day Year
s, P.(es that the de igned by the be detached	by Phy	Part II. Other signifi	cant conditions	contributing to death	but not re	sulting in the un	derlying ca	use giver	n in Part I.		23e. Did t	obacco	use contrib	ute to ti	ne cause of death?
ord	v requir been si should	ted										10	Yes 2	N 0 3	☐ Prob	ably 4 Unknown
	The larate has	Completed	CHRONIC	: LYMPHO	OCYTIC I	EUKE	CMIA					24a. Was auto perfo		Drie	or to co ath?	psy findings available mpletion of cause of 2 No
Vital	ysician: Th is certificate director, pag	Be	25. Was case referrexaminer?	ed to medical	14							(Check only o				
o	Phys this al dii	lon: To	1 ☐ Yes 2 1 1 27. Manner of Death	5 Pending			ER/Outpatient 28b. Time of Injury	28	lc. Injury a Work?	at	2	ne 5 X Resi 8d. Describe	dence how inju	6 Other	(Specif	y)
Division	l or Attendater death	flcat	2 ☐ Accident 3 ☐ Suicide	investigatio 6 Could not be determined	e 28e. Place of	njury - At h	ome, farm, stre	M et. factory		es 2⊡N	-	8f. Location (Street ar	nd Number	or Rura	l Route Number,
á	oital or a urs after ral Dira	Certification:	4 Homicide		building,	etc. (Speci	fy)	_				City or To	νπ, State	o)		
	To tha Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	edical	29a. Certifier (Check only one)	1 A Certifying Pi 2 Medicel Exa	nysicien: To the bearings: On the basis and manner	or examina	owledge, death ation and/or invi	occurred a estigation, i	t the time in my opii	, date and nion, death	place, ai occurre	nd due to the d at the time,	cause(s) date and	and mann d place, and	er as si	ated. the cause(s)
	To the within To the comple	Ž	29b. Signature and	itle of certifier	3. (1/			License					te signed (/		
1				Z_	M. 2	4	/		351	92			JUI	Y 5,	20	005
	5		30. Name and addre KEVIN G	ss of person who	14816 P				#25:	3, R	OCKV	/ILLE.	MD	20	850	
: 2=	Sta Registr		31. Date filed (Month	JUL 0 5	32. Regi	ar's Signa	ature	Ann. 8				<i>I</i>				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 4 Day 2005 ea Fawn Minnie /Medical 10:30P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ruxton Health of Denton Denton Caroline If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Min. May 4, 1919 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 20XF Director 327-05-1298 86 Illimis Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 27 Is marked other then "neturel", or items 23e or 28e-f show treumatic event, Ing Madical Examiner must be notilised at 10d. Inside City Limits Yes 2 □ No Directo Maryland Queen Anne's Queenstown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Main Brace Drive 21658 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. illed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 212 No þ Specify: 3 ☑ Widowed 4 □ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be ည Samuel Orion Logan Bessie Priscilla Brooks 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Joanna M. Laslo Daughter 306 North Main Street, Berlin, Maryland 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of the Importent: If Ite any Injury or ot once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 7/6/2005 Dover, Delaware 21. Sur ature of Funeral Service Licenses 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and De Immediate Cause (Final disease or condition resulting in death) **Physician** ebrovascu /Medical Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dire to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ło in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by pe dementia 3 ☐ Probably 4 ☐ Unknown director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Paursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 1 L Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending after death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 6/05 S-Washington St Easton up 2/601 address of person who completed cause of death (Item 23a) (Type, Print) nus) Date filed (Month, Day, Year) 3 Registrar's Signature State JUL 0 6 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Margaret Helen Cooper 1950 2005 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easton If Under 1 Year | If Under 24 Hrs. Hospita Memorial Tal 60 Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Months Hours 1 ☐ M 2 💢 F Director Yrs. 213-44-5761 78 June 18 1927 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "neturel", or items 23a or 28a-f show other treumatic event, if a Modical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24821 Meeting House Road 21629 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) homemaker ll yrs own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Fielding Nickerson Mary Ruth Benney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Importent: If item 27 is
any injury or other treu Charles F. Cooper, Sr./ husband 24821 Meeting House Road Denton, MD 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Greensboro Cemetery 107/06/05 ^ 4 □ Donation 5 □ Other (Specify) Greensboro, Maryland 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, MD 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute rena Days disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** mointestina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 2 0 2/Z)No 1 ☐ Yes Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one. examiner? Hospital: 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JULY OS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. Washington St. Easton, MD Lakshmi Vaidyanathan 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 0 6 2005 Registrar

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			1 - For State Registrar	State of	Marylan	id / Depa <i>Cei</i>	artment of F rtificate of	lealth an <i>Death</i>	d Mental Hy	giene Reg. No. 0	15	23373
			Decedent's Name (First, Middle						2. Date of De	ath		3. Time of Death
Н	Physici		Coences C	rantoro	1				June	29 20	Year 05	1:50 A M
1	/Medio Examin		4a. Facility Name (If not institutio	n, give street and numb	per)		4b. City, Town, o	r Location of D		4c. County of		11.50 11
Y			Shady Grove A	dventist Nu	rsing	Home	Rockvi	11e		Montg	omer	У
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da	th v. Year)		place (State or Foreign
d fr	Director		456-32-0309	1 ∑ M 2□F	80	Yrs.	Wolfing Days	110010	Mar. 1		Texa	
	pung *		Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Aaryli r sho	ō				ermant						1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number	gomery	G	ermant	10f, Zip Code			10g. Citizen of W	hat Cour	ntn/2
	With Sa or		13438 Ansel	Terrace			2087	74		United		•
	ns 2	Funerai	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin'	? (Specify Yes or No			can Indian,
36	itied within 72 hours after death with the Maryland Hygiene. kther than "natural", or items 23e or 28e-f show int, ilie Medical Examiner must be notified at		1 Never Married 2 Mar	If Yes, Give	Mo		if Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, P	uerto Rican, etc.)		, White,	
21215-0036	tural'	ed by	3 Widowed 4 Divorced	Year or Date	9S: 	16a Dagg	death Heyel Occur	ation		1		ite
<u>.</u>	in 72	Completed	(Specify only highe	st grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kind of Bus	iness/inc	dustry
7	withi ene.	E C	Elementary/Secondary (0-12)	College (1-4	or 5+)		acturer	·		Sales		
D O	Hyg Hyg pther ent,	0	17. Father's Name (First, Middle,	Last)		1			Name (First, Middle,	, Maiden Sumame)	
<u>a</u>	ld be ental ked k	ToB	George Bedf	ord Crawfor	d			Iva	Pittman			
Maryland	shound M	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street	and Number o	r Rural Route Numbe	er, City or Town, S	tate, Zip	Code)
	aith a		Betty R. Cra	wford / Wif	e	13438	Ansel T	errace	Germanto	wn, Mary	1anc	1 20874
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	2 Demondifican St	1 0	lace of Dispo	sition (Name of natory or other plac	э) Ј	uly 1,	20c. Location - C	ity or To	own, State
<u>Ĕ</u>	Pag nent ant: h		*4 □Donation 5 □Other (S		1	ropoli	tan Crema		2005	Alexand	ria,	Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, Ilia Machael Examiner must be notified at 9069.		21. Sign Jure of Funeral Service	Licensee Licensee			Name and Addre		DeVol Fun	eral Home	e MD	20877
			23a. Part1. Enter the disease, o	r complications that cau	sed the deat							Approximate
4	Physician		shock, or heart failure. List Immediate Cause (Final	, only one cause on eac		C7	ncer					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or	as a conseq		111001				-	months
	Examiner		21-57-00 T-0-000		,	,						
-	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dua to (or	as a conseq	uence of):						
	rcutec nd transi	Examin	that initiated events	c							_	
Ö,	icate be executed physician and s the burial-transit	Ě	resulting in death) Last	Due to (or	as a conseq	uence of):						
8760,	ate b	dical		d								
9	ertific ding p	/Me	IF FEMALE:	220 16 1100 01100								-
Вох	eath certific attending p	ian	23b. Was decedent pregnant in the past 12 months?		ne or pregna h 2 ∐ Feta it at time of d	I death 3	Ectopic pregnancy	,		23d. Date Mont		Day Year
o.	that the de led by the a detached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow		eam 5	Other (specify)					
۵.	res that igned by be deta	y Ph	Part II. Other significant conditi	ons contributing to deal	th but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contrib	oute to th	ne cause of death?
Records,	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	ed by							_ 10`	Yes 2□No 3	Prob	ably 4 Junknown
00	w requires been si	Completed							24a. Was	an 24b. W	ere autor	psy findings available
Re	The law ate has page 2 :	E								rmed? de	ior to cor ath? ⊒Yes	mpletion of cause of
ta		0	25. Was case referred to medica	н				26. Place of	1 ☐ Yes Death (Check only of		7 192	2 140
>	Physicien: r this certifica ral director, I	To B	examiner? 1 Yes 2 No	Hospital: 1 Inp	atient 2	ER/Outpatien	t 3 DOA Oth		ng Home 5 ☐ Resid		(Specify	y)
0	ding Physicien: After this certific funeral director,		27. Mann of Death 1 ⑤ Natural 5 ☐ Pendir	28a. Date of I	Injury Day Year)	28b. Time of Injury	28c. Injun Wor	v at		now injury occurred		
Sio		cati	2 Accident investi	igation			M 1 🗆	Yes 2 □ No				
Division of Vital	or Attendate death after death Director:	Certification:	3 Suicide 6 Could 4 Homicide	nined 289. Place of	Injury - At ho , etc. (Specify	ome, farm, str y)	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	or Aura	I Route Number,
_	pitel ours a eral I	Ce	29a. Certifier 1 Certifyin	ng Physicien: To the be	not of my kee	wladaa daath	a constant at the time		lana and dun to the			
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical one)	Examiner: On the basi and manner	s of examina	tion and/or in	vestigation, in my o	pinion, death o	occurred at the time,	date and place, an	d due to	the cause(s)
	Vith To t	Σ	29b. Signature and title of pertifie	7	0	c	29c. Licens	e number	ac.	29d Date signed	Month, L	Day, Year)
	9		1 / 2	V-1).	olung		h.	401	18	June		1 6005
_	•		30. Name and address of person	who completed cause of	of death (Item	()	sell A	vc (levilties	1 pouc	Nd	.20879
	Sta Registr		31. Date filed (Month, Day, Year) JUN 3 0	2005 Reg	istrar's Signa	ture	des					

			For	State	of Maryland		artment of F		d Mental H	ygiene		
			1 - State Registrar			Ce	rtificate of	Death		Reg. NO	105	23371
H	Physic	an	Decedent's Name (First, Mid					-	2. Date of D Month	eath Day	Year	3. Time of Death
	/Medi		Monzel		cellous		Collins, S		JULY	04, 200		09:54 a.M
	Exami	ner	4a. Facility Name (If not institut		umber)		4b. City, Town, or		eath		unty of Death	1
	F		Memorial H 5. Social Security Number	6. Sex	7. Age (In yrs. las	st hirthday)	CUMBE If Under 1 Year	RLAND	Hrs. I a Date of B		EGANY	1 - 0 - 5 - 1
	Funeral Director		236-20-0776	11 M 2□F	84	Yrs.	Months Days		Min. 8. Date of B (Month, D 06/13/	ay, Year)	Col	nplace (State or Foreign untry) t Virginia
	ס		Usual Residence of Decedent	1					00/13/	1721	wes	t Viigiiia
	arylar	_	10a. State 10b. Coun	,	10c. City,	Town or Lo	ocation					10d. Inside City Limits
	8a-f	cto	MD	Allegany			Cumberland					1 ☐ Yes 2X No
	with th	ä	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?
	eath	erai	10202 Jeffi		sedent Ever in U.S.	10.1	2150		2 (2)		USA	
98	be filed within 72 hours after death with the Maryland ntal Hygiene. ad other then "neturel" or items 23a or 28a-f ehow event, the Medical Examinar must be neithed at	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Armed F			Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2☑ No	spanic Origin' n, Mexican, Pi Specify:	? (Specify Yes or Nuerto Rican, etc.)		Race - Amer Black, White	
21215-0036	hours turel'	d by	3 ☑ Widowed 4 □ Divorce	ed Year or L	Dates: WWII						ecify:	White
햔	in 72	Completed	(Specify only high	ent's Education lest grade completed))	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	uring most of	working	16b. Kind o	of Business/li	ndustry
212	filed within Hygiene. sther then "gent, I'm Wes	ome	Elementary/Secondary (0-12)) College (1-4or 5+)	<i>m</i> 0. 1	Laborer	,		Con	structi	OD
Þ	e filed Il Hygid Other Vent,	BeC	17. Father's Name (First, Middle	e, Last)			Laborer	18. Mother's	Name (First, Middle			OII
Maryland	should be and Mental marked o	To E	James		Collins			Maude	Rache1		Inknown)	
Mar	2 8 20 10		19a. Informant's Name/Relation				ng Address (Street a					p Code)
e,	1 and 2 Health em 27		John C. Collins,	Sr. / son	20h Plac	10202	Jeffiers H	Road, Cur	mberland, M			
100	Pages nent of I int: If its		1 ØBurial 2 ☐Cremation		Oldio		sition (Name of natory or other place			20c. Locati	on - City or T	own, State
Baltimore,			' 4 □ Donation 5 □ Other		∣ MD Ve		n @ Rocky Ga . Name and Addres		/08/2005 Adoms Famili			Maryland
Ba	permit. Departr Importa eny inji		11/1/	10.					et, Cumberl			21502
	W-11		23a. Part1. Enter the disease, shock, or heart failure. Li.	or complications that	aused the death.	Do not ente					,	Approximate
	Physician		Immediate Cause (Final disease or condition	Coc		10	rlaru		ease			Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to	(or as a conseque	nce of):	11019	,	الساك			
	Examiner		Sequentially list conditions,	b								
	ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due tu	(or as a consequen	ice of):						
6	xecut and al-tran	хап	that initiated events resulting in death) Last	c. Due to	(or as a consequer	nce of):						
68760,	ficate be executed physician and is the burial-transit				(
687		edicai		d								
Вох	death certifi e attending ed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnanc					23d.	Date of deliv	erv
	0 0 0	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		pirth 2 Fetal denant at time of deat		Ectopic pregnancy Other (specify)				Month	Day Year
P. O.	at the	Phys	9 🗌 Unknown									
	The law requires that the de ate has been signed by the a page 2 should be detached	by	Part II. Other significant condit	tions contributing to d	eath but not resulti	ng in the un	derlying cause give	n in Part I.				he cause of death?
0.0	requi	eted							- 10	Yes 2□No	3 Prot	pably 4 Junknown
3ec	2 2 2	Completed				-			24a. Was	osy	prior to co	psy findings available mpletion of cause of
ā	ilcian: Th								1 ☐ Yes	2 No	death?	2□ No
Division of Vital Records,	Attending Physician: The r death. ector: After this certificate hiby the funeral director, page	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No	Hoenital	and a	-	3CI DOA Othe		Death (Check only o			
ō	g Phys er this eral dii	⊢ da	27. Manner of Death	28a. Date	of Injury 28	Outpatient Bb. Time of	28c. Injury Work	4 Changini	g Home 5 Resi			(y)
0	nding ath. r: After e funer	atio	1 2 Natural 5 ☐ Pend 2 ☐ Accident inves	ing (Moni tigation	th, Day Year)	Injury		es 2 □ No				
<u> </u>		Certification;	3 Suicide 6 Could 4 Homicide deten	mined 200. Flace	of Injury - At home	, farm, stre	et, factory, office		28f. Location (Street and Nu	mber or Rura	al Route Number,
	itelo rs aft rel Di led in				ng, etc. (opecny)				City or To	vii, State)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical		ing Physician: To the	asis of examination	dge, death and/or inv	occurred at the time	, date and pla	ace, and due to the	cause(s) and	manner as s	tated.
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifi	A and man	ner stated.		29c. License					
2	F \$ # 8		b and this or certifi	WLL	3		D3328			JULY		
J	1.1	+	30. Name and address of persor	who completed caus	e of death (Item 33	Ra) (Tumo F				OOFI 2	, ,	2005
71.	RS		Sunil Gupta M.I				erland, N	farylan	d 21502			
	Sta	е	31. Date filed (Month, Day, Yea		egistrar's Signature			-				
	Registra	ar	OUT DI	LUUJ	Mille So	fred to	els					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. N2 () 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Marsha 9:15 AM 26, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. M. Chaels

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Company | Hours | Min. | (Month, Day, Year) North Street albot 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral 1□M 2 F 218-07-5310 Usuel Residence of Decedent 96 Yrs. Director July 1, 1908 Mary Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Be Completed by Funeral Director MD Talbot Michae 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? NORTH 2166 US 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. of Health and Mental Hygiene. If them 27 is marked other than "natural", or Item or other traumatic event. It a Modical Examiner. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ₺ No Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

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16a. Decedent's Usual Occupation

16b. Decedent's Usual Occupation

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16b. Decedent's Usual Occupat 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private Residence Work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ samuel Jeanette 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 619 W. Glenwood Ave. Easton, Maryland 21601

Date 20c. Lication - City or Town, State Jeanette Caldwell Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. 05 St. Michaels * 4 ☐ Donation 5 ☐ Other (Specify) Thomas Mem. Cemetery 22. Name and Address of Fitching Henry Funeral Home, P.A. 510 was hington str cambrid 21. Signature of Funeral Service Licensee of MD. 2/6/3 Approximate Interval Between Onset and Death 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician com disease or condition resulting in death) 2 wee h /Medical Due to (or as a consequence of): **Examiner** 2000 Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit Luaniti w Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ensin 1 ☐ Yes 2 12 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 ☐ Yes 2 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 - Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

chilling, 555 Cynwood Drive, Easton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Russell Schilling,

004258

29d. Date signed (Month, Day, Year)

			For State Registrar	State of I	Maryland		artment of			lental Hygi	ene 9. NQ N () E	22276
	Physici /Medic		Decedent's Name (First, Mid		Crushon	g	•			2. Date of Death		Year	3. Time of Death 10:00 P. M
	Examir		4a. Facility Name (If not instituti 17715 Lo	on, give street and number ower Georges Cre	ek Road	S.W.	4b. City, Town	n, or Location LC	of Death nacor		4c. County	of Reath	gany
	Funeral Director		5. Social Security Number 213-57-4435 Usual Residence of Decedent	6. Sex 7	Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Ye Months Day		24 Hrs. Min.	8. Date of Birth (Month, Day, December 29	Year)), 1999	9. Birthi Cou Pe	place (State or Foreign ntry) nnsylvania
Maryland	in a show	tor	10a. State 10b. Coun Maryland	Allegany	10c. City,	Town or Lo	ocation	Lonacor	ning	·			10d. Inside City Limits 1 ☐ Yes 2 🗷 No
th with the	23a or 28a ast be not	al Director	10e. Street and Number 17715 Lower	Georges Creek R	oad S.W.		10f. Zip Cod	21539)	10	g. Citizen of	What Cou U.S.A	ntry?
d 21215-0036 filed within 72 hours after death with the Maryland	antinent or release and section of the marked other then "neturel", or flems 23s or 28s-1 show njury or other treumstic event, the Madical Examinar must be notified at a.	by Funeral	11. Marital Status 1 X Never Married 2 Ma 3 Widowed 4 Divorce	If You Give	S? No		Was Decedent of Yes, specify C			ecify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. White
21215-0036 ad within 72 hours af	nygiene. other then "netu ant, the Medical	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed) College (1-40)	r 5+)	(Give	dent's Usual Oci kind of work do DO NOT use ret	ne during mos	t of work	ing	6b. Kind of B	nsiness/In	
/lan	Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle	Unknown						e (First, Middle, M. Janet			
	regim and tem 27 is mo			nship (Typa, Print) Iiller-caregiver		. 11	7715 Lower		reek R	al Route Number, oad S.W., Lo			
Baltimore,	Important: If its any injury or off		20a. Method of Disposition 1	(Specify)		metery, crer	sition (Name of matory or other p I Hill Ceme			y 08, 2005	Mosco	-	own, State , Maryland
e a	any n		21. Signature of Funeral Servic	Kemi		E		Kenzie Fu	neral H			onacon	ing, Md. 21539
	ysician ledical		23a. Part1. Efter the disease, shock, of heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	- Kes	DIVO	Not	er the mode of d	lying, such as	cardiac c	r respiratory arres	·t,	2	Approximate Interval Between Onset and Death Weeks
	aminer	er	Sequentially list conditions, if any, leading to immediate	. Pulr	s conseque	WU	ede	ma	_			2	Weeks
cate be executed	ysician and ie burial-transit	ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Deep Due to (of a	s a conseque	ence of):	300			1 bosis		6	months
DS/DU	윤는	fedical		a. IYlet	astat	hc	Neu	urob)	last	omb		3	YEARS
.O. BOX of the the death certification	I by the attending patached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal d	leath 3□	Ectopic pregnar Other (specify)				23d. Dat Moi	e of delive	ery Day Year
Ords, P	been signed t should be det	þ	Part II. Other significant condit	ions contributing to death	but not result	ing in the ur	nderlying cause	given in Part I.		23e. Did toba	,		ne cause of death?
The law	cate has	e Completed	25. Was case referred to medic								id? g	rior to cor leath?	psy findings available inpletion of cause of
2 £	this al di	To B	examiner? 1 ☐ Yes 2 🌠 No 27. Manner of Death 1 🛣 Natural 5 ☐ Pend:	Hospital: 1 ☐ Inpa 28a. Date of In	jury 2	VOutpatien 8b. Time of Injury	28c. In	other: 4 Nu	rsing Hon	Check only one) ne 5 (3 Residence 8d. Describe how		(-)	()
of or Attending	I Director	Certification:	3 ☐ Suicide 6 ☐ Could	mined 286. Place of I	njury - At hom atc. (Specify)	e, farm, stre	et, factory, offic	9	2	28f. Location (Stree City or Town, S	et and Numbe State)	er or Rura	l Route Number,
To the Hospitel or Attending	To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 🔏 Certifyi 2 Medica	ng Physician: To the best I Examiner: On the basis and manners	ot examination	edge, death n and/or inv	occurred at the estigation, in my	time, date and opinion, deat	d place, a	and due to the caused at the time, date	se(s) and mai and place, a	nner as stand due to	ated. the cause(s)
Tot	Tot	Σ	29b. Signature and title of certific	w m	Nul	uni	29c. Lice	nse number	MD		Date signed	- 1	one
			30-Name and address of person	who completed cause of Wuber W	death (Item 2	За) (Туре,	Idren	s Mor	lixi	2 000 m	Breen	STRE	No Mandage
	Star Registra		31. Date filed (Month, Day, Year JUL	7 2005 Negis	trar's Signatur	re di	South				7		- In fact to the

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. N6) 2. Date of Death 1. Decedent's Name (First, Middle, Last Day **Physician** THELMA HILDA DENVER July 1, 2005 10:43 P[™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic general Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min 1 □ M 2 X F Months Hours Director 88 214 22 1607 June 1, 1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumatic event, the Mudical Examiner must be notified at 1√Yes 2□No Director Maryland Worcester Ocean City the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21842 Items 23c U.S.A. Funerai 12531 Salisbury Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married o Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3X Widowed White 4 Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 in and Mental Hygiene. 7 is marked other then "ne Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lula Ware Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n any injury or other treun 506 32nd St. #4 Ocean City, MD 21842 Doug Denver 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ⁴ 4 □ Donation Frankford, DE Cape Henlopen Crem. 7/2/05 al Service Licensee 22. Name and Address of Facility 108 William St. The Burbage Funeral Home Berlin, MD 21811 Jula 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final epsi. Pnysician disease or condition resulting in death) /Medical Due to (or is a consequence of): Examiner pacteremia Sequentially list conditions, in any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ M6 Month Year page 2 should be detached for Day 4□Pregnant at time of death 5 Other (specify) been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Ho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has i 2 No 1 ☐ Yes Hospital or Attending Physician: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Division of V Hospital: 1 ☐ Yes 2 ☐ No 1 npatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Alatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 536/2 1/05 1) Are 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Health way Dr. Berlin, 733 MO 31. Date filed (Month, Day, Year) State JUL 0 5 2005 Registrar

			State of Maryland / Department of Health ar 1- State Registrer Amond #100 & 18 Per. Fam. RC Cr. Certificate of Death	-	ygien	e	22270
			Registrar Amend #10e. & 18 Per Fam. PGC cr Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Oate of I			3. Time of Death
	Physici /Medi		ANA EDELMIRA MENDEZ DE TORRES	JUNE	28.	ay Year 2005	11:46A ^M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of I			c. County of Death	
			SOUTHERN MARYLAND HOSPITAL CLINTON			RINCE GE	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Nonths Days Hours 1 Nonths Days Hours 1 Usual Residence of Decedent	Min. 8. Date of E (Month, I JULY 1		9. Birth Cou VENE	place (State or Foreign intry) ZUELA
	yland now		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mar Me-f st	tor	DISTRITO FEDERAL CARACAS				1 ☐ Yes 2√ No
	be filed within 72 hours after death with the Maryland that Hygliene. ad other then "neturel", or Items 23e or 28e-f show event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number QTA. LA TORRERA CALLE & COLINAS DE VISTA ALEGRE NONE			itizen of What Cou ENEZUELA	•
	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No	lo-	14. Race - Ameri Black, White,	
36	rs afte		1 □ Never Married 2 □ Married 1 □ Yes 2 ② No If Yes, Give 1 ☑ Yes 2 □ No Specify: V		1	Specify: HI	
9	2 hou atura	ted	15. Decedent's Education 16a, Decedent's Usual Occupation		16b. h	Kind of Business/In	ndustry
21215-0036	within 7 ene. than "n he Med	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)				
	e filed within al Hygiene. I othar than ' vent, the Me		17. Father's Name (First, Middle, Last)			OVERNMEN'	<u> </u>
Maryland	should be find Mental Himarked of	To Be	AURELIO MENDEZ RAMIREZ EDETMI	Name <i>(First, Midde</i> LMERA SAL IRA	AS M	ONCADA	
Mai	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) DAUGHTE: 19b. Mailing Address (Street and Number of CARMEN-ROSA TORRES MENDEZ 7105 LADY SLIPPER L.				
Ē,	es 1 an of Heal fitam 2 r other		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		ocation - City or To	
Ë	0 0 = =		1 □ Burial 2 🛱 Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) METROPOLITAN CREMATORY	6-30-05	ALE	XANDRIA,	VIRGINIA
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3	MARSHALL' • SUITLAN	S FU D, M	NERAL HOND 20746	ME OF MD, IN
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.	rdiac or respiratory	arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Herning in death)				Onset and Death
	Examiner		Due to for as a koonsequence of):				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	mine			
	be executed sician and burial-transit	Examiner	trial initiated events c.	000			
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Вох	death certifica attending ph d for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	əry
o.	requires that the death certificate be executed teen signed by the attending physician and hould be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Month	Day Year
<u>α</u>	res that signed b	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco	use contribute to th	he cause of death?
ord	w require been sig should b			_ 1□	Yes 2	□No 3□Prob	ably 4 XUnknown
Vital Records,	law as b 2 s	ompleted		24a. Wa:	psy	24b. Were auto	psy findings available mpletion of cause of
a F	Th ate pag	O		peri 1 🗆 Yes	ormed? 2. X No	death? 1 ☐ Yes	2□ No
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	g Phys er this eral di	F-19	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ng Home 5 Res			7)
ion	Attanding I r death. actor: After by the funer	atlo	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	11			
Division	To the Hospital or Attanding Ph within 24 hours atter death. To tha Funarel Diractor: Alter th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To		nd Number or Rura	I Route Number,
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	To the within 2 To tha complet	Me	29b. Signature and title of certifier \ 29c. License number			te signed (Month,	
1	A)		D004158	0	0	29.05	•
P	45	1	30. Name and address of past o complete cause of death (Item 23a) (Type, Print)				
	Sta	te	31. Date filed (Month, Day, Year)	MICA	<u>U /,</u>	22	
	Registr	ar	JUN 3 0 2005 Keen & pool				

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			For State	State of Ma	aryland		artment o			ind M	ental Hy	-	000			
			Registrar 1. Decedent's Name (First, Middle, L	ast)		06	incate	OI L	Calli		2. Date of D	Reg. No	20(15	23	379
	Physic		Michae	el Dillaro	a Des	vi 110					Month June	28		Υθαr 2005	7:0	PM
	/Medi Examir		4a. Facility Name (If not institution, g			VIIIC	4b. City, To	wn, or	Location of	f Death	oune_		County		1700	
		ü	21182 Marsh Cr	eek Road	Lo	t 28	Pre	sto	n				Car	olir	1e	
	Funeral		Social Security Number 6.	Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Months	Year Days	If Under 2 Hours	4 Hrs.	8. Date of Bi	irth				or Foreign
	Director		213-64-4423 Usual Residence of Decedent	TUNN ZUF	5(0 Yrs.		,,,			etder		954		ylan	
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation								Od. Inside (
	Many Ffsh	to	Maryland Caroli	ne	D	restor	,									s 2 N 0
	th the	Director	10e. Street and Number			LCSCOI	10f. Zip Co	ode				10g. Citi	izen of W	hat Count	try?	
	th will	aiD	21182 Marsh Cree	k Road Lo	ot 28		216	555				Unit	ed S	tato	e of	Amerio
	or dea	Funerai	11. Marital Status	12. Was Decedent Armed Forces?			Vas Deceden f Yes, specify	t of His	panic Origi Mexican	in? (Spec	cify Yes or N	0-	14. Race	- America	an Indian.	THELL
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 GYes 2 □ N If Yes, Give	∾ 191 191	/2	I□Yes 2∏X		Specify:							
21215-0036	d within 72 hours after death with the Maryland glene. Ir than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at	ed b	15. Decedent's I	Year or Dates:	19.		lent's Usual C	\aaumat	ion						asian	
215	c * @	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed)		(Give	kind of work of OO NOT use i	done du	ring most o	of workin	g	160. KI	na of Bus	siness/Ind	ustry	
213	filed withli Hygiene other than	mo:	12	College (1-4or 5)+)	В	arber					Hai	ir Ca	are		
nd	be filed Ital Hygi d other event, II	Be	17. Father's Name (First, Middle, Las	t)				1	18. Mother	's Name	(First, Middle	, Maiden	Surname	9)		
yla	should be nd Menta marked matic ev	2		d Deville					Bei	rnac	line A	Anna	Neh	rin	a	
Maryland	2 shour and M is mari		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (S	treet an	nd Number	or Rural	Route Numb	er, City o	r Town, S	State, Zip (2-4-1	1655
	permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg Importent: If item 27 is marked othe any injury or other traumatic event, ODEs.		Robin Deville 20a. Method of Disposition	Wife	205 Bio	21182	Marsh	Cn	eck R	oad,	Lot 2	28, P	rest	on, I	aryl	and
Baltimore,	Pages nent of I int: If ite		1 □ X urial 2 □ Cremation 3		Md	metery, cren Laster	n Shor	r place) C	1	Da	ite	20c. Lo	cation - C	City or Tow	n, State	
語	permit. Page Department of Importent: If any injury or once.	-	 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice 	-	Vet	erans'	Cemet	ery	7	/5/2	005	Beul	ah,	Maryl	and	
Ba	permi Depa Impo any ir		Acu Copy	house		M	Name and A	une	ral H	ome,	P.A.					
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	plications that caused	the death.	1	2 Sout	h S	econd	_St.r	eet. D	ento	n, M		and 2° Approxima	
	Pnysician		Immediate Cause (Final	A	10 November 100									1	nterval Be Onset and	tween
	/Medical		disease or condition resulting in death)	a. A CU TE Due to (or as a	a conseque	ence of):	DIAL	I	VEAR	CI	DN			- 1	CUTE	
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	p is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a conseque	ence of):						2614	-		,,,,,,,	110
	and I-tran	xam	that initiated events resulting in death) Last	c Due to (or as a	2 00000000	2000 06):										
8760,	icate be executed physician and s the burial-transit	aiE		500 10 (01 23 2	a conseque	erice or).										
687	= 0.2	edicai		d												
Вох	death certifi e attending p od for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of								2	3d. Date	of delivery	,	
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at 1			Ectopic pregn Other (s <i>pecif</i>)	ancy y)					Monti			Year
о. О	that the de led by the a detached t	hys	9 🗆 Unknown	9□ Unknown												
ń	The law requires that the tee has been signed by the page 2 should be detached	þ	Part II. Other significant conditions	contributing to death bu	it not result	ting in the un	derlying cause	e given	in Part J.		23e. Did t	obacco us	se contrib	ute to the	cause of c	leath?
orc	requi	eted								_	10	Yes 2□] No 3	☐ Probab	oly 4 🌉 l	Jnknown
Record	e law has t	Completed								_	24a. Was autop	sy	pri	or to comp	y findings pletion of c	available ause of
				·							1 ☐ Yes	rmed? 2 € No	1 C	ath? Yes 2	□ No	
Vita		o Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital:		5/0		Other:			Check only o					
ō	ding Phys h. After this funeral di	\vdash	27. Manner of Death	1 ☐ Inpatier	y 2	R/Outpatient 8b. Time of		Injury a Work?			d. Describe l					
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Division of	tet or Attendi s after death. el Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At hom	ie, farm, stre	et, factory, off	ice		28	f. Location (S City or Tox	Street and	Number	or Rural F	Route Num	ber,
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	To the Hospitet or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Pl 2 Medical Exam	nysician: To the best of miner: On the basis of o	examinatio	edge, death n and/or inv	occurred at the	ne time, ny opin	date and p	olace, an	d due to the a	cause(s) a	and mann	ner as state	ed. ne cause(s)
	o the	_	29b. Signature and title of certifier	and manner stat	. ea.) SOUTH	29c. Lic							Month, Da		·
	- S - O		Maritian 6	Jangow Me	0 1	M H	NII	1//	1			17/	7/1	111	11-	
			30. Name and address of person who	completed cause of de	ath (Item 2	(Type, F		-00	4		- 6	440	14	X U	73	
_			Christian E. Jer	sen. M.D.,	РО В	ox 690	•	on.	Mary	zlanc	21629					
	Stat	е	31. Date filed (Month, Day, Year)	32 Registrar	r's Signatui	re d	A 10		<u>Y</u>		1.74_					
	Registra		JUL 0 8 20													

Amended #19a, nls, 07/12/05, Allegany

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar				Ce	rtificate c	of Death		Reg. No	005	233
an	Decedent's Nam							2. Date of De Month	ath Day	Year	3. Time o
al -	HOWARI							107	10	05	30.
er			ive street and numb			4b. City, Tow	m, or Location of Deal	th	and the same	County of Deat	
	5 Social Security N				last birthday)		NBERLANI ear If Under 24 Hrs			ALLE C	
	214-12-		1 X M 2□F	83	Yrs.	Months Da			ıy, Year)	2 MAT	hplace <i>(Stat</i> e duntry) RYLAND
	Usual Residence o							DAIN. Z	1,192	Z MAR	KILAND
	10a. State	10b. County			ty, Town or Lo						10d. Inside C
Director	MD	ALLEG	ANY	CU	MBERLA	ND					1 X Yes
Oire	10e. Street and Nu					10f. Zip Cod			10g. Citiz	en of What Co	untry?
la l	420 AVII	RETT AVE	NUE			2150	02			S.A.	
Funeral	11. Marital Status		12. Was Decede Armed Force	es?		Was Decedent of Yes, specify C	of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.))- 1·	 Race - American Black, White 	
by Fi	1 Never Marr	ried 2 Married	If Yes, Give			1 □ Yes 2 X 0	No Specify:		5	Specify: TA	HITE
	3 🗆 Widowed	15. Decedent's I	1	es: WWII	1	dontin House Oa	an mation		1Ch Kin		
jete		cify only highest g	rade completed)		(Give	dent's Usual Oc kind of work do DO NOT use re	one during most of wo	rking	160. Kin	d of Business/I	Industry
Completed	Elementary/Seco	ondary (0-12)	College (1-4	lor 5+)		CHINIST			R/	AILROAD)
0	17. Father's Name	(First, Middle, Las	st)				18. Mother's Na	me (First, Middle			
To B	HOWARD	LEVI D	ENEEN				ALICE	MOUNTA	IN		
-	19a. Informant's N	ame/Relationship	(Type, Print)		19b. Maili	ng Address (Str	reet and Number or Ri	ural Route Numb	er, City or	Town, State, Z	(ip Code)
	ROBERTA		COMPANIO	N	420	AVIRET	TT AVENUE,	CUMBERL	AND,	MD 21	502
	20a. Method of Dis	•			Place of Dispo	osition (Name or matory or other	f place)	Date	20c. Loc	ation - City or	Town, State
		☐ Cremation 3 5 ☐ Other (Spec	☐Removal from Sta cify)	are	-	ROCKY C	· · · · · · · · · · · · · · · · · · ·	3/2005	FL	INTSTON	E, MD
Ì	21. Signature of Fu	uneral Service Lice	ersey		22	2. Name and Ad	dress of Facility				
	· Coo	Not VI	tepche	1C		202 GRE	CH FUNERAL			D. MD	21502
	23a. Part1. Enter t	the disease, or co	mplications that cau				JUNE STREET				
- 1		ed failure. List onl	v one cause on eac	ised the deat	h. Do not ent		dying, such as cardia				Approximat
	Immediate Cause	rt failure. List oni (Final	y one cause on eac	sh line.							Approximatinterval Bet Onset and
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Division of Vital Records, P.O. Box 68/60, To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunar-transit

	Please Type or Print in State of Maryla				•	-	
_1	State Registrar		rtificate of L	Death	Reg.	0000	23381
an cal	1. Decedent's Name (First, Middle, Last) Robert Emery Do	wney			2. Date of Death Month June 28,	Day Year	3. Time of Death 2:50 a M
	ta. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dear	
	Collingswood Nursing & Rehab 5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	Rockvi		B. Date of Birth	Montgome	ery thplace (State or Foreign
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크	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 12. Was Decedent Ever in Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give 10		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2K No	spanic Origin? (Spen n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: To	e, etc.
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edicai Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the bast of my 2 Medical Examiner: On the basis of example and manner stated.						
	29b. Signature and title of certifier		29c. License	number	29d.	Date signed (Mont	h, Day, Year)
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		15 Medio	cal Cente	r Drive,	#201, Roc	kville, 1	MD 20850
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State of Maryland / Department of Health and Mental Hygiene

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2		\$ g	23a Parti Enter	the disease	omplications that	raused the deat								pproximate
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2		Physician /Medical	Immediate Cause	(Final	· V	M.					0 -	. \		oriodi and Dodan
1		Examiner	disease or conditi resulting in death)	on	a	175	1000	PDIA(_	AN FA	120717	N .		
0	4					Due to (d	or as a consec	uence of):	_	AN FA			1	
(1)		lad is		4	b	Co	RON E	Hers)	H	RIBRY	DISE	ASE	ŀ	
0.8		rentificate be executed ding physician and ise as the buriel-transit	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease o	onditions,		Due to (d	or as a conseq	uence of):						
Q	68760,	ician burie	cause. Enter Und Cause (Disease o	erlying r injury	C									
	87	sete the	that initiated event resulting in death)	S		Due to (o	r as a conseq	uence of):						
~	9 ×	ing p			d									
2	Вох	- c = E			- 0									
3	<u>.</u>	Attending Physician: The law requires that the deeth or deactors. If deach a strong the attence of the attence of the attence of the funeral director, page 2 should be deteched for unfilteration: To Be Completed by Physician	Part II. Other signi	ficant condition	s contributing to de	eath but not res	ulting in the ur	nderlying caus	e give	en in Part I.	23b. Did	tobecco use c	ontribute to t	he cause of death?
Q	9.	at the	A A	"CIDI	FIBR	10125	100				10	Yes 2 No	3 Proba	bly 4 ☐ Unknown
Z.	Ś	gnec be d	1	777	1-752	1 5001	10 N							
X	D.	been si should l									24a. Was	an autopsy	24b. Were	autopsy findings
217	ပ္တ	s be s sho									penc	rmed?	comp	oletion of cause
40	æ	he taw e has age 2 :									40	/a. 0 1985-		
	ā	hysician: The la nis certificate had director, page 2	25. Was case refe	rred to medical								res 2 TNo	10.	res 2□ No
	5	sician certifi iractor	examiner?		Hospital:		5010		Othe	26. Place of Deal				
	Division of Vital Records,	Physic this corral dire	27. Manner of Dear		28a. Date		ER/Outpatien 28b. Time of			4 Lanvursing Ho	ome 5 Resident			
	LO C	Affing P. Affiner funer	1 ANatural	5 Pending investigat	(Mont	th, Day Year)	Injury		Injury Work	? ∕es 2 □ No	200. Describe	iow injury occu	ilea.	
	2	death death ctor: y the	2 ☐ Accident 3 ☐ Suicide	6 Could no	t be	-61-1 441				165 2 140	000 1 1			
	\leq	+	4 - Homicide	determin	ed 286. Place buildir	of Injury - At ho ng, etc. (Specify	ome, tarm, stre y)	et, factory, off	ice		28f. Location (S City or Tox	Street and Num vn, State)	ber or Hural F	loute Number,
		or and or or or or or or or or or or or or or	00 0 17	1										
		Ne Hospital or Attending Pi Az hours after death: Ne Funeral Director: Attert pletely filled in by the funeral edical Certification:	29a. Certifier (Check only	1 ← Certifying 2 ☐ Medical Ex	Physician: To the carniner: On the ba	isis of examinal	wledge, death tion and/or inv	occurred at the estigation, in r	e time	e, date and place, inion, death occur	and due to the red at the time.	cause(s) and m	anner as stat and due to th	ed. ne cause(s)
		To the Hospital of within 24 hours of the Funeral Discompletely filled it weekling Medical Cer	one)		and main	ier stated.								
		5.¥ 5.00 €	29b. Signature and	unie of certifier				29c. Lic	ense	number		29d. Date signe	d (Month, Da	y, Year)
		1/20	7 4	The_	MD			D65	53	06		JULY	5	2005
	per	· DB	30. Name and addr	ess of person wh	no completed caus	e of death (Item	23a) (Type, F	Print)				-	1	
	_ '	mls	DENN	15 -1+.	ODIE	9106	VHI LA	DEUH	MA	FD S	CUTE 2	O BA	140. L	y, Year) 2005 1021237
	1 8	State	31. Date filed (Mon	th, Day, Year)	2. R	egistrar's Signa	ture	w .						
		Registrar	JUI	_ 0 8 200	US Class	New St.	13/2004							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death June 29, 2005 **Physician** 3:30 PM William Walter Eyers /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Casey House Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 24, 1919 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 X M 2 □ F Connecticut Director 049-03-8857 86 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other then "neturel", or Items 23e or 28a-f show other treumstic event, the Nedical Evarified at 1 ☐ Yes 2 No Director Maryland Montgomery Potomac 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20854 10209 Garden Way USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Engineer/Consultant Utility Companies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clara Preston Walter Eyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19322 Frenchton Place Montgomery Village, MD 20886 Elizabeth Eyers Wolk/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny injury or ot once. July 1, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Arundel Crematory ^¹ 4 □ Donation 5 □ Other (Specify) Odenton, Maryland 2005 21. Signature of Funeral Service L Going Home Cremation Service P.O. Box 784 MO125|Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Malignant Neoplasm, Colon with Matastases disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine ed by the attending physician and detached for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 Tes 2 🗆 No 1 Yes 2 🔀 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ Other (Specify) $_{0}$ Spice P 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After 1 XNatural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Charles M. Harrison M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

13430

6001 Muncaster Mill Rd. Rockville, MD 20855

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2:30p Lewis A. Fraley 28 2005 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 9141 Gue Road Damascus Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 12XM 2□F Director Maryland 215-36-5522 66 June 1, 1939 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9141 Gue Road 20872 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 AYes 2 No If Yes, Give Year or Dates: 1956-59 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Plumbing Plumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maurice Fraley Mable McAtee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10403 Fountain School Road, Union Bridge MD 21791 Michael Fraley/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 7/6, 2005 4 Donation 5 Other (Specify) Montgomery Methodist Damascus, Maryland Cemetery 22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 21. Signature of Funeral Service Licensee 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ESOPHAGEM c ARCINDMA **Physician** resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial-Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by I , page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No certificate 2 No 1 ☐ Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 Nursing Home 2 ER/Outpatient Certification: To 3□ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funaral Diractor: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur D35635 V D June 29, 2005 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan MD 18111 Prince Philip Drive, Olney, Maryland Suite 327 31. Date filed (Month, Day, Year) 32. Registra s Signature State 0 1 2005 JUL Registrar

DHMH 17 Rev 1/2001

1 - State Registra
1. Decedent's

For

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. N2. 0 0 5

Physician
/Medical
Examiner

s Name (First, Middle, Last)

Faulkner Fannie

89

2. Date of Death Month Day

June

4a. Facility Name (If not institution, give street and number) 4400 Garrett Park Road

6 Sax

4b. City, Town, or Location of Death Silver Spring 20,2005 10:00a 4c. County of Death

Funeral

Usual Residence of Decedent 10b. County

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday)

8. Date of Birth (Month, Day, Year) 12/15/1915

9. Birthplace (State or Foreign

10d. Inside City Limits

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show

Physician

/Medical

Examiner

burial-transit

the t

Exam

Physician/Medical

by

Completed

Be

2

Certification:

Medical

Baltimore, Maryland 21215-0036

MD

10c. City, Town or Location Montgomery

1 □ M 2 🖾 F

Silver Spring

1 ☐ Yes 2x No 10g. Citizen of What Country?

Montgomery

10e. Street and Number 4400 Garrett Park Road

10f. Zip Code 20906

USA

11. Marital Status

1 Never Married 2 Married 3 □ Widowed 4 □ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 XNo fYes, Give If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

Race - American Indian, Black, White, etc.

Black

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 12

College (1-4or 5+)

Homemaker

Own Home

Specify:

Jackson Nesbitt

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co29 455 3636 Marshfield Rd. Johns Island, S.C.

18. Mother's Name (First, Middle, Maiden Sumame)

Thomas Mueller/Executor

20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State 7/01/05 Rockville, Md Parklawn Mem.Pk.

Essie Jones

4 □ Donation 5 □ Other (Specify) 21. Signat r - f Funeral Servi - icenses /

23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia BLvd.Silver Spring, Md20910

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of)

Cerebro Vascular Accident

vears

Approximate Interval Between Onset and Death

sudden

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Atherosclerosis Due to (or as a consequence of)

Hypertension

Due to (or as a consequence of)

years

Year

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death

d

3 Ectopic pregnancy

23d. Date of delivery Month Day

9 Unknown

4☐Pregnant at time of death 9□ Unknown

5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

1 Yes 2 No 27. Manner of Death

1 XNatural

29a. Certifier

2 Accident

5 Pending investigation 6 Could not be 28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ★ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D31319

29d. Date signed (Month, Dey, Year) June 29,2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr.Loreto Abiol

8218 Wisconsin Aave. #305 Bethesda, Md 20817

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) **3 0** 2005 32 Registrar's Signature

or Attanding Physician: The law requires that the death certificate be executed attending physician and Division of Vital Records, P.O. Box 68760, After after death filled in by the Eunaral I within 2 To tha To the

ID

			For State Registrar	State of Ma	ryland / Depa	artment of I		-	iene _{eg. N} 2005	23386
	Discontinu		1. Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death
	Physici /Medi		Marcy Lynn Gr	oss				June 2	0 Day 2005	12:25A M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of De	
			Suburban Hospit	a1		Bethesd	a		Montgom	ery
	Funeral		5. Social Security Number 6. Se	x 7. Age ☐M 2√2 F	(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
	Director		430-36-6072	- M 284 F	54 Yrs.			Sept. 1	9,1940 I	llinois
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				Transition of the
	lanyl sho	ō				oution.				10d. Inside City Limits
	28a-1	Funeral Directo	Maryland Montgome	ry	Bethesda	1017:01				71
	with	Ö				10f. Zip Code			0g. Citizen of What 0	Country?
	eath	era	7029 Barkwater Ct.	10 Was Dandert 5	10 I do	20817			U.S.A.	
1.2	iter d	ü	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?		f Yes, specify Cub	Hispanic Origin? (Spo an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	
36	l', or	by	3 Widowed 4 XDivorced	1 ☐ Yes 2 N If Yes, Give Year or Dates:		1 ☐ Yes 2 ₹ ☐ No	Specify:		Specify: V	√hite
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Exarifret must be notified at	ed	15. Decedent's Edu		16a, Dece	dent's Usual Occur	pation		16b. Kind of Busines	c/lodustar
15	n n	Completed	(Specify only highest grad	e completed)	(Give	kind of work done DO NOT use retire	during most of work	ing	TOD. KING OF BUSINES	sindustry
212	d within jiene. r than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+	•)	cy Analy			Federal Go	vernment
b	illed Hygie othar ant,	Be C	17. Father's Name (First, Middle, Last)	····			18. Mother's Name			VOLIMIONIC
ā	lid be lental rkad o	To B	Comer Lynn				Virgin	ia James		
Maryland	should and Men marka umatic		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	g Address (Street	t and Number or Rura	il Route Number,	City or Town, State,	Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is markad othar than "natural", or items 23a or 28a-f show may injury or othar traumatic avant, the Medical Examination and once.		Alexandra Drees-Gr	oss / Daug					on, D.C. 2	
Baltimore,	of He		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date 2	20c. Location - City o	
Ë	Pages nent of lint: If its		1 ☐ Burial 2X☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		Mt. Comfo		Julic		\levendrie	a, Virginia
Ħ	artm ortal		21. Signature of Funeral Service Licens				-		ler's Sons	
ã	permit. Departr Importa any inju	15	Williams R.	B				_		DC 20016
			23a. Part1. Enter the disease, or compl	ications that caused t	he death. Do not ent					Approximate
	Priysician		Immediate Cause (Final	ie cause on each line						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		ntestinal consequence of):	Bleedin	8			
В	Examiner				gulation v	with Cour	modin			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	with cour	liautii			
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Atrial	Fibrillat:	ion				
Ć.	exec in an ial-tr	Еха	resulting in death) Last		consequence of):	2011		·		
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dlcal		1.						
9	ifficate g phys as the	ed								
Вох	death certifica attending ph of for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o					23d. Date of de	livery
	death a atte d for	icla	in the past 12 months? 1 ☐ Yes 2X No	1□Live birth 2 4□Pregnant at ti		Ectopic pregnancy Other (specify)	y		Month	Day Year
0	that the ded by the detached	hys	9 🗆 Unknown	9□ Unknown						
۳.	The law requires that the the has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions cor	ntributing to death but	not resulting in the ur	derlying cause giv	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
rds	quire n sig uld b							1 □ Yes	s 2 Q No 3 □ P	robably 4 Unknown
Records,	w requir	Completed						24a. Was an	24h Were a	utopsy findings available
Re	The lavate has	m C						autopsy	prior to	completion of cause of
		Ö	25. Was case referred to medical						□ No 1 □ Yes	2 □ No
5	Physician: this certific ral director,	To B	examiner?	lospital:	2 ER/Outpatien	Oth	26. Place of Death			
	Phy r this sral c		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur	4 Nursing Hon	ne 5∟Hesider ?8d. Describe hov	nce 6 Other (Spe	cify)
Division	Attanding I ar death. ector: After by the funer	Certification:	1 □XNatural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year) Injury		k? Yes 2 □ No			
İSI	or Attandi after death. Director: A in by the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At home, farm, stre		_	8f. Location /Stre	eet and Number or R	ural Route Number
Di	2 2 2 6	erti	4 Homicide determined	building, etc.		,,,		City or Town,	State)	arar route reamber,
	spits cours neral		29a. Certifier 1 X Certifying Phys	sicien: To the best of	my knowledge, death	occurred at the tin	ne date and place, a	and due to the car	ise(s) and manner as	stated
	e Ho 24 r a Fu letely	edical	(Check only 2 Medical Examinate)	ner: On the basis of e and manner state	xamı#atıøn and/or inv	estigation, in my o	pinion, death occurre	ed at the time, dat	e and place, and due	to the cause(s)
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	Me	29b. Signature and title of certifier	1	11	29c. Licens	e number	29	d. Date signed (Mont	h, 🍞 ay, Year)
	, , , ,		V /n	Do rel	/.	(A)	32208		1-121	105
•	12	-	30. Name and address of person who co	mnlefed cause of day	th (Item 23a) Type, R	Print)	7 3 000	,	01011	01
			Dr. Harry J. Bigha	' //	410 Rockle	,	#200 Bath	acda Ma	ruland 20	Q17
	Sta	te	31. Date filed (Month, Day, Year)				"200 DECII	coud, ria	Tyrand 20	01/
	Registr		JUL 01 200	General	s Signature	Ce P				

Gross, Marcy, 6/20/05,

		1 - For State Registrar	State of Maryla			of Health of Death		F	Reg. No	005	233	387
cia:	_	Decedent's Name (First, Middle, THOMAS GIBSON						2. Date of Dea Month JUNE	Day 30	2005°	3. Time of 1:41	P N
ine		4a. Facility Name (If not institution,	give street and number)		4b. City, To	own, or Location	of Death		4c. 0	county of Death	1	
		FREDERICK MEMOR			FREDE					EDERICE		
il r		5. Social Security Number 217-32-6479 Usual Residence of Decedent	6. Sex 7. Age (In yr	s. last birthday Yrs.	If Under 1 Months I	Days Hours	r 24 Hrs. Min.	8. Date of Birtl (Month, Day 10/28/1	(, Year)	9. Birth Cos	nplace (State ountry) MI	
	1	10a. State 10b. County	10c.	City, Town or L	ocation					1	10d. Inside C	ity Limit
١.	ţō	MD Carrol	L1 M	t. Airy	7						1 🗌 Yes	2 ⊋ N
	Funeral Director	10e. Street and Number 4101 Baltimore N			10f. Zip C					en of What Cou	untry?	
1	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Deceder	nt of Hispanic O	rigin? (Spe	ecify Yes or No- Rican, etc.)		4. Race - Amer	ican Indian,	
١.	ል	1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		If Yes, specify 1 ☐ Yes 25			Rican, etc.)		Black, White	hite	
	eted	15. Decedent's (Specify only highest		(Giv	edent's Usual (done during mo	st of worki	ing	16b. Kin	d of Business/l	ndustry	
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired) Engine			υ	nk		
	BeC	17. Father's Name (First, Middle, L	ast)			18. Moth	er's Name	e (First, Middle,	Maiden S	lu <i>mame)</i>		
1	6	Thomas Lewis Gib	oson, Sr.			Cam	illa	Madalir	ne Ro	hrer		
	- J	19a. Informant's Name/Relationsh. William P. Youns						al Route Numbe				
-		20a. Method of Disposition	20b	. Place of Disp		of		-		ation - City or T		
		1 ☐ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.	3 □Removal from State ecify)	-	-		07/06	6/2005	Smit	hsburg	MD	
		21. Signature of Funeral Service L		7 2	2. Name and	Address of Facil	ity Ger	cald N.	Minn	ich Fur	neral H	
	dicai Examiner	shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Possification of the constant of the consta	equence of): 1 M/1 O equen of):		ur ut l	lail	uif			Interval Bet Onset and I	
4	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of prec 1 Live birth 2 Fe 4 Pregnant at time of	□Ectopic pregnancy □ Other (specify)					23d. Date of delivery Month Day Year			
	à	Part II. Other significant condition	ns contributing to death but not r	underlying cau	se given in Part	l.		id tobacco use contribute to the cause of death? Yes 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Ponknow} \)				
1	ete							-				
	Completed							24a. Was a autop: perfor	sy med?	death?	opsy findings ompletion of c	
1	Be	25. Was case referred to medical examiner?	Manital				e of Death	(Check only or	10)			
Įŀ.	0	1 Yes 2 No	Hospital: 1 Dinpatient 2 28a. Date of Injury	☐ ER/Outpatie				me 5 Resid			rfy)	
1	Certification:	27. Man of Death 1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	28b. Time of Injury	of 280	t. Injury at Work? 1 ☐ Yes 2 ☐		28d. Describe h	ow injury	occurred			
0	Certifi	3 Suicide 6 Could no 4 Homicide determin		home, farm, si city)	rm, street, factory, office 28f. Location (Street and Number or Rural Route Number City or Town, State)					iber,		
	Medicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my k xaminer: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred at nvestigation, in	the time, date at my opinion, de	nd place, a ath occurre	and due to the c ed at the time, d	ause(s) a late and p	nd manner as lace, and due	stated. to the cause(s	3)
2	Σ	29b. Signature and title of certifier	To M.	υ.	29c. L	icense number	08	71 2	9d. Date	signed (Month	Day, Year)	
111	-	30. Name and address of person w	no completed cause of death (It	em 23a) (Type	. Print)			1	_/_	100	·	
		Michelle Tan, M	. /00 ** 7.1 ~			1 3.00	0170	71				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

			For State Registrar	State of	of Marylar				lealth a Death	and M		iene	15	23300	
			1. Decedent's Name (First, Midd	fle, Last)							2. Date of Dea	th		3. Time of Death	_
	Physici /Medio		GENEVIEVE	LOUISE	GARBER	}					Month JULY	Day 20	Yeer 05	6:20 PM	Λ
	Examir		4a. Facility Name (If not institution	on, give street and nu	imber)		4b. City	Town, or	Location of	of Death		4c. Count	y of Death		_
			7846 HENSON	LANDING	ROAD		1	ELCO	ME			CF	IARLI	ES	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2/CXF	7. Age (In yrs.		If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign	n
	Director		578-24-1156	10 m 200	81	Yrs.					FEB.18			RYLAND	
	and and		Usual Residence of Decedent 10a. State 10b. Count	у	10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits	
	f sho	ō	MARYLAND CH	ARLES	TA7 E	LCOME								1 ☐ Yes 2√DXNo	
	the 28a	Director	10e. Street and Number	AKLES	771	LCOME		o Code				0g. Citizen of	What Cor	intry?	_
	3a of	0	7846 HENSON	T. AND TNG	ROAD			206	0.3						
	ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U		Was Dece	dent of H	spanic Ori	gin? (Spe	cify Yes or No-	14. Ra		ican Indian,	_
9	or Ite	Ē	1 Never Married 2 Ma	rried Amed Fr	2 X No					i, Puerto I	Rican, etc.)		ck, White	, etc.	
8	72 hours after death with the Maryland natural: or Items 23a or 28a-f show ileal Examinar must be notified at	d by	3	d Year or D	Dates:		1 🗌 Yes	Z V J∕ V 0	Specify:			Speci	ry: WF	HITE	
21215-0036	72 h	Completed	15. Decede (Specify only high	nt's Education est grade completed)		16a. Dece	kind of wo	ork done c	turina mosi	t of workii	ng	16b. Kind of E	Business/Ir	ndustry	
121	within ene. than	d m	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT L	ise retired)						
	filed v Hygie other t		12 17. Father's Name (First, Middle			LAND	DIS	SPOS		rlo Noma	(First, Middle,			ERNMENT	_
auc	ould be I Mental I harked oi	Be	HARRY A. NIC										me)		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ms	ပို	19a. Informant's Name/Relation			19h Mailir	na Addres	c (Straat :			S. KNO I Route Number		Ctato 7	o Codo)	
Ma	d 2 s th an th an trau		MICHAEL A. G		N						L CERF	-			
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 1 I Health 23 or 28a-f show then transatic event. The Medical Examinar must be notified at		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of				20c. Location			-
υŌ	ages ant of it: If I		1 Burial 2 Cremation 4 Donation 5 Other (State	cemetery, crei	-	•		_					
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Itam 27 any injury or other tr. <u>once</u> .		21. Signature of Funeral Service		METROP M00479				ATOR		5-05	ALEXA	NDSI	A, VA	-
Ba	Depa Impo any ir		mal.	01	MO04/9						SERVIC	E, PA			
			23. Part1. Enter the disease, o shock, or heart failure. Lis	or complications that	caused the deal	th. Do not en	er the m	e of dylin	d. sull A	SHIEG	ND iratory 2	646		Approximate	_
	Physician		Immediate Cause (Final	t only one cause on	1									Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to	(or as a consec	Dog.									
	Examiner		•	0		120									
١,,,		Je.	Sequentially list conditions, if any, leading to immediate	Due to	(or as a consec										
	s be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cauce. Enter underlying Cause (Disease or injury that initiated events	G											
o	e exe ian al	E	resulting in death) Last	Due to	(or as a conseq	(uence of									
8760,	requires that the death certificate be execu een signed by the attending physician and nould be detached for use as the burial tra	dical		d									-		_
9	ing p	Med	IF FEMALE:												
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant	1 Live	tcome of pregna birth 2 Teta	al death 3	Ectopic p						ate of deliv	ery Day Year	
o.	the a	/slc	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregi 9☐ Unkr	nant at time of o	leath 5□	Other (s	oecify)					OTTO 1	Day Tour	
P.0	that the de led by the a detached i	Ph	Part II. Other significant condit	ions contributing to d	leath but not res	sulting in the u	nderlying r	rause dive	on in Part I		23e Did to	acco usa con	tribute to t	he cause of death?	_
Records,	w requires that been signed k should be deta	d by		3			,	3			1 🗆 Y	V	3 ☐ Pro		1
Ö	> 9 7	ete									04- 146	- , ,	14/	Continue	_
Re	e ta has	Completed									24a. Was a autops perform	y	prior to co death?	opsy findings available impletion of cause of	,
_	ician: Th certificate rector, pag		OF Was ages referred to modis	21							1 Yes	No	1 🗆 Yes	2 No	_
Vital		o Be	25. Was case referred to medic examiner? 1 Yes 2 W No	Hospital:	Innation 2/	15D/0		Othe			(Check only on				
		. To	27. Manner of Main	28a. Date	of Injury	ER/Outpatier 28b. Time of		28c. Injury Work	4 🗆 140	rsing Hon	8d. Describe h	ence 6 0tl		(y)	-
O	iding Phi th. : After thi funeral	tlor	1 Natural 5 Pend 2 Accident invest		nth, Day Year)	Injury	м		(? Yes 2 □ !			, , , , , , , , , , , , , , , , , , , ,			
Division	r Attending er death. rector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	e of Injury - At h	ome, farm, str	eet, factor	y, office		2	8f. Location (Si	reet and Num	ber or Run	al Route Number,	-
É	al or	Sert	4 Homicide deter	build	ling, etc. (Specil	'y)					City or Town	n, State)			
	Hospital Hospital Funeral tely filled		29a. Certifier 1 Certify	ing Physicien: 70 the	e best of my kno	owledge, deat	h occurred	at the tim	ne, date an	d place, a	nd due to the c	ause(s) and m	anner as s	stated.	-
	To the Hospital or Attencywithin 24 hours efter death To the Funeral Director: completely filled in by the 1	edical	(Check only 2 Medica	i Examiner: Op the b	pasis of examina nner stated.	ation and/or in	vestigation	i, in my or	oinion, deal	th occurre	d at the time, d	ate and place,	and due t	o the cause(s)	
	To the vithin 2 To the complet	Σ	29b. Signature and title of certifi	er			29	c. License	number		2	9d. Date signe			
			177	7//		M])33	426			7/5	105	•	
	16		30. Name and address of person	who completed cau	se of death (Iter	n 23a) (Type,					01	P			
	15		D. Carry Je	nkins,	mD - 1	11 6	Gro	unqu	2 Ac	x,l	aPla	ta, M	D 20	2046	
	Sta Registi		31. Date filed (Month, gay, Year JUL 1	6 2005	agistrar's Signa	M. L	coste			•					

			_	State of Ma						•		-	
		1-	For State Registrar						Death		Reg. N		23389
Physi	cian		Decedent's Name (First, Middle, Las							2. Date of Month	D	ay Yee	
/Med			MICHAEL LYNN Facility Name (If not institution, give	HINES			4b. Ci	tv. Town,	or Location of De	JUNE		2005 c. County of De	6:25 A M
Exam	iller		WASHINGTON COUNT		L				RSTOWN			ASHING:	
Funera		5. S	ocial Security Number 6. Se		e (In yrs.	last birthday)		ler 1 Year		n. 8. Date of (Month,			Sirthplace (State or Foreign Country)
Directo	r		13-68-6334		48	Yrs.				NOV.	l6, 1	.956 N	1ARYLAND
ryland	_		. State 10b. County		10c. Cit	y, Town or Lo	cation			<u> </u>			10d. Inside City Limits
the Marylar 28a-f show	ecto	M	ARYLAND WASHING	STON			1		STOWN		-	·	1 ☐ Yes 2 X No
be filed within 72 hours after death with the Maryland lat Hygiene. of other then "natural", or Items 23a or 28a-1 show event, the Medical Exarction must be redified at	Funeral Director	2	. Street and Number 1822 WHITE OAK RO)AD			10f.	Zip Code	21740		10g. C	itizen of What U.S.	
death	nera	11.	Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13.	Was De		Hispanic Origin? an, Mexican, Pue	(Specify Yes or	No-	14. Race - Ar	nerican Indian,
s after deal	by Fu		1 Never Married 2 Married	1 ☐ Yes 2 🔯 f If Yes, Give	10			2 <mark>⊠</mark> No		erto Nicari, etc.)		Black, W	
hours tural	ed b		3 ☐ Widowed 4 X Divorced 15. Decedent's Edi	Year or Dates:	_	16a, Dece	dent's II	sual Occur	nation		16h	Kind of Busines	WHITE
hin 72 9. 9n "na	Completed	E	(Specify only highest gradelementary/Secondary (0-12)	le completed) College (1-4 or 5	(+)	(Give	kind of	work done	during most of w	rorking	100.	Talle of Desiries	samuatry
filed with Hygiene. other ther	Con		12				INS	SULAT					L INSULATION
d 2 should be file the and Mental Hy 27 Is marked oth treumatic event	Be		Father's Name (First, Middle, Last)							ame (First, Mide			
2 should be and Mental is marked of reumatic even	To		ARL LEON HINES a. Informant's Name/Relationship (T	ype, Print)		19b. Mailir	ng Addre	ss (Street	and Number or	RGINIA Rural Route Nur			, Zip Code)
7 5 7 7		D	ARLENE L. GRIFFI	TH/COMPANI	ON	21822	WH	TE O	AK ROAD,	HAGERS	TOWN	, MARYL	AND 21740
Pages 1 nent of He int: If Iten		20a	. Method of Disposition 1 ☎Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. F	Place of Dispo semetery, crea	sition (finatory o	lame of r other pla	сө)	Date	20c. l	Location - City	or Town, State
Pa		-	4 □ Donation 5 □ Other (Specify		MA				ETERY 7/	The second secon	-		MARYLAND
permit. Departm Importe		21.	Sign (ture of Funeral Service License	Paul M	. De				AL HOME			ational Maryla	
-		23	a. Pan1. Enter the disease or comp shock, or heart failure. List only	lications that caused	the deat	h. Do not ent	er the m	ode of dyi	ng, such as cardi			тагута	Approximate Interval Between
Physicia	n	dis	mediate Cause (Final ease or condition	Atherosi	4 1	ie co	rd:	vas	cular i	disew	e		Onset and Death
/Medica Examine		res	sulting in death)	Due to (or as	a conseq	uence of):							
	e l	Sed if a	quentially list conditions,	b. Due to (or as	a conseq	uence of):							
uted ''	Examiner	Cau	quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or injury t initiated events	c									
ate be executed ysician and "	Exa	res	ulting in death) Last	Due to (or as	a conseq	uence of):							
cate b physic the b	dical			d									
The law requires that the death certificate tate has been signed by the attending physispage 2 should be detached for use as the t	Physician/Med	1F F	FEMALE: D. Was decedent pregnant	23c. If yes, outcome							Į.	23d. Date of c	lelivery
death e atte	icial	200	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic Other	pregnanc (specify)	y 		_]	Month	Day Year
that the de ed by the a detached t	Phys		9 Unknown	9 Unknown	-						-		
ires tha signed d be de	ρ	· i ai	till. Other significant conditions co	ntributing to death b	ut not res	ulting in the u	nderiying	g cause gr	en in Part I.		d tobacco ⊒ Yes 2		to the cause of death? Probably 4 Dunknown
w require been sig should b	ietec									24a. W			autopsy findings available
The law ate has page 2	Completed									au ./ pe	topsy rformed?	prior t death	completion of cause of
	BeC	25.	Was case referred to medical examiner?						26. Place of D	1 X Yes		0 1 X Y	es 2□No
o o	은		1 Yes 2□ No	Hospital: 1 Inpatie	4.3	ER/Outpatier		JOA		Home 5□Re	esidence	6 □Other (Sp	pecify)
ding F h. After funera	tion	27.	Manner of Death Natural 5 Pending investigation	28a. Date of Inju (Month, Da	Year)	28b. Time of Injury	М	28c. Inju	ryat rk? Yes 2 ⊡ No	28d. Describ	e how inj	ury occurred	
Attending Physiclen: r death. sector: After this certific by the funeral director.	Ifica		3 Suicide 6 Could not be	28e. Place of Inj	ury - At h	ome, farm, str			7.03 2 1110				Rural Route Number,
i di di	Certification:		4 Homicide	building, ef	c. (Specif	y)				City or	Town, Stai	te)	
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical		(Check only 2 Medical Exam	sicien: To the best iner: On the basis of	examina	wledge, death	occurre estigati	ed at the ti	me, date and place	ce, and due to the	ne cause(:	s) and manner nd place, and d	as stated. ue to the cause(s)
thin 2 the o	Med	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,											
N V			IN W,	mid				OCM	Ξ			E 29, 2	
		30.	Name and address of person who d	ompleted cause of d	eath (Iten	n 23a) (Type,	Print)	Da	- C.L ·	D 7.			
.10									n Street	Balti	more,	Maryla	and 21201
5	State	31.	Date filed (Month) DIV, YOr)1 2	005 32. Hegistr	ar's Signa	iture	a. M	'					

State Registrar

			1 - For State Registrar	-	artment of Health and I rtificate of Death		jiene	23390
ı	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day 2005	3. Time of Death 12:10 A ^M
	/Medic Examin		Jane D. Horning 4a. Facility Name (If not institution, give street as	nd number)	4b. City, Town, or Location of Death		4c. County of De	
	Exami		Casey House		Rockville		Montgomer	ry
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 № 1	7. Age (In yrs. last birthday, 76 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day May 13,	1929 Mai	rthplace (State or Foreign Country) ryland
	ow II		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Man e-f sh	ctor	Maryland Montgomery	Gaithers	ourg			1 ☐ Yes 2 No
	or 28	Directo	10e. Street and Number		10f. Zip Code	1	Og. Citizen of What C	Country?
	eath v	Funeral	10212 Millstream Drive		20886 Was Decedent of Hispanic Origin? (S	pecify Yes or No-	USA	nerican Indian.
320	be filed within 72 hours after death with the Maryland tal Hyglene. Id other then "natural", or items 23a or 28e-1 show event, the Mydiral Examiner must be notified at	by Fun	1 Never Married 2 Married 1 If Ye	ed Forces? Yes 2X No es, Give ir or Dates:	If Yes, specify Cuban, Mexican, Puert □ Yes 2X No Specify:	o Rican, etc.)	Specify: Wh:	ite, etc.
9500-6121	72 hou	ted	15. Decedent's Education (Specify only highest grade comple	16a. Dece	dent's Usual Occupation	rking	16b. Kind of Busines	
Z	vithin 7 ne. hen "r	Completed		ege (1-4or 5+)	DO NOT use retired)		TT 1.1	
N	Hygi ther nt,		17. Father's Name (First, Middle, Last)	4 X-Ray	Technician 18. Mother's Nar		Healthcare Maiden Surname)	2
yland	Aental Aental rkad c	To Be	Dewey W. Dodson		Mae St.	Clair		
Mary	s 1 and 2 should be f if Health and Mental H item 27 is marked of other treumetic eve	_	19a. Informant's Name/Relationship (Type, Prin	nt) 19b. Mail	ng Address (Street and Number or Ru	ıral Route Numbe	r, City or Town, State,	Zip Code)
	l and fealth om 27 her t		Norma D. Lopatin/POA/I	Friend 10214	Millstream Drive		sburg, MD 20c. Location - City o	20886
פֿב	nt of H		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal	from State cemetery, cre	matory or other place) Jun	ne ^{ate} 30 , 2005 0	denton, Ma	
galtimore,	permit. Pages I Department of H important: if ite any injury or ot once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral/Service Licenses /		2. Name and Address of Facility Coing Home Cremati			
ñ	Dep imp any		Bevel L. Hel		oing Home Cremati Beverly L. Heckrot			
	Pnysician /Medical			e on each line.	ter the mode of dying, such as cardiac		est,	Approximate Interval Between Onset and Death
	Examiner		. De	eep Vein Thrombo	sis			
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٥	certificate be executed nding physician and use as the burial-transit	ledic	U					
J. BOX	death e atter	Physician/Me	in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	elivery Day Year
J.	requires that the de been signed by the a hould be detached f	Phy	9 ☐ Unknown Part II. Other significant conditions contributing	g to death but not resulting in the s	underlying cause given in Part I.	23e, Did to	bacco use contribute	to the cause of death?
ds,	= 0, 0	d by		gg				Probably 4 Unknown
Hecord		ompieted				24a. Was a		utopsy findings available
	The la	mo				autops perfor	med? death?	completion of cause of
Vital	sicien: The law certificate has l irector, page 2 s	Be C	25. Was case referred to medical examiner?			ith (Check only or	ne)	
0	hy his	۲:	1 ☐ Yes ② No Hospital: 27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury 28b. Time of			ence 6 XOther (Sp.	ecify)hospice
	iding th. : After fune	tion	1X Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	of 28c. Injury at Work? M 1 Tyes 2 No	200. 5000100 11	ow injury occurred	
DIVISION	of or Attending Pater death. I Director: After the in by the funera	Certification:	a Till and the	Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Si City or Town	treet and Number or F	Rural Route Number,
5	spitei or ours aft nerel Di filled in							
	9 4 7 5	edical	(Check only 2 Medical Examiner: On	To the best of my knowledge, deal the basis of examination and/or in manner stated.	th occurred at the time, date and place evestigation, in my opinion, death occu	, and due to the c rred at the time, d	ause(s) and manner a ate and place, and du	is stated. ie to the cause(s)
	To the h within 24 To the F complete	Me	29b. Signature and title of certifie		29c. License number	2	9d. Date signed (Mon	th, Day, Year)
}			1 /Kan	ms	D35635	J	une 29, 20	005
			30. Name and address of person who completed		Print)			
	Sta	ate	Joseph Kaplan M.D. 600	32 Registrar's Signature		ии 20855		
	Regist		JUL 1 200	5 Alexan J.	Lugaret 1			

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. NO. 1 5 . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 Year EUGENE ERWIN HALMOS, JR. JULY 3 19:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 15201 MONTEVIDEO ROAD POOLESVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, AUG 24 **Funeral** Birthplace (State or Foreign Country) 191<u>6</u> 1 MM 2□ F 88 529-01-2096 Director NY Usual Residence of Decedent death with the Manyland 10a. State 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits the Medical Examiner rust by notified at 1 ☐ Yes 2 No Director MONTGOMERY MD POOLESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15201 MONTEVIDEO ROAD 20837 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 No. 1942 If Yes, Give 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) JOURNALIST PUBLISHING other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H is marked of permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked c any injury or other traumatic eve 2008. EUGENE E. HALMOS, SR. ROSE-ELLEN GYORY ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE SCHROEDER/NIECE 145 SOUTHWEST ARBOR ST., PULLMAN, WA 99163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) FREDERICK CREMATORY 7/5/05 FREDERICK, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOPULMONARY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ADVANCED DEMENTIA 5yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit CHRONIC OBSTRUCTIVE PULMONARY DISEASE 10 yrs Due to (or as a consequence of): Box 68760. Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I performed certificate 2 X No 1 🗆 Yes 2 🗆 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{YOther} \) (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. M 1 ☐ Yes 2 ☐ No after death investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide within 24 hours a To the Funeral D pellij Medicai 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who 🕟 plet : cause of death (Item 23a) (Type, Print) 5 DR. XIE, MARTINSBURG VA HOSPITAL, 510 BUTLER AVE., MARTINSBURG, WV 31. Date filed (Month, Day, Year) 32. Registras Signature State

DHMH 17 Rev 1/2001

Registrar

2005

			1 - For State Registrar	State of Maryl		artment of I			giene	5 23392
	Physici	an	Decedent's Name (First, Middle, Last) TOURS			-		2. Date of De Month	eath Dav Y	3. Time of Death
	/Medic	al	VIRGINIA ELAINE 4a. Facility Name (If not institution, give s			4b. City. Town	or Location of Deat	June	29, 200 4c. County of	
н	Exami	er	107 East Main Stre			Thurm		•		erick
	Funeral Director			7. Age (In y	rrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		3, 1944	9. Birthplace (State or Foreign Country) Maryland
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	e Man 3e-f sh Liffe J	ctor	Maryland Frederic	k	Thurmon	t				1√ Yes 2□ No
	th with th	al Dire	10e. Street and Number 107 East Main Stre	et		10f. Zip Code 2178	8		10g. Citizen of Who	•
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "netural", or items 23a or 28e-f show any injury or other treumatic event, it a Madical Examinar must be notified at QDGs.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0	American Indian, White, etc. White
Baltimore, Maryland 21215-0036	i within 72 ho piene. r than "netur ir e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire Custodia	during most of word)		16b. Kind of Busin Frederick Board of	
land;	uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) Thomas Brice				18. Mother's Nam Catherin		, Maiden Sumame) ick	
, Mar,	and 2 sho salth and P n 27 la ma er treuma		19a. Informant's Name/Relationship (Typ. Kathy E. Hurley (D.						er, City or Town, St. urg, MD 2	
more	Pages 1 and of He sent of He sent: If item		20a. Method of Disposition 1 XBurial 2 Cremation 3 Re 1 Donation 5 Other (Specify)			sition (Name of natory or other place) e. Cemete:		Date	20c. Location - Cit Thurmont,	ty or Town, State Maryland
Balt	permit. Departr Importe any inji		21. Signature of Funeral Service Licent	e	R0 6.	Name and Addre DBERT E. 15 EAST N	ess of Eacility DAILEY & IAIN STRE	SON FUI	NERAL HOM RMONT, MD	ES, P.A. 21788
Ī			23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	cations that caused the die cause on each line.	eath. Do not ent	er the mode of dyir	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a cons	Can C	er				11 years
	Examiner		Sequentially list conditions b							
	ted 1sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Cissass or Injury	Due to (or as a cons	sequence of):					
oʻ	icate be executed physicien and s the burial-transit	Exar	that initiated events cresulting in death) Last	Due to (or as a cons	sequence of):					_
8760,	ate be hysicie the bu	dlcal	d	-						
O. Box 6	ath certif ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)	/		23d. Date o Month	,
a.	uires that the de signed by the a Id be detached f	by	Part II. Other significant conditions con	tributing to death but not	resulting in the ur	nderlying cause giv	en in Part I.	23e. Did t		ite to the cause of death? ☐ Probably 4 ☐ Unknown
Records,	The law requirate has been single has been single 2 should	Completed						24a. Was autor perio	an 24b. Wer prio primed? dea	re autopsy findings available r to completion of cause of th?
Viita		Be Co	25. Was case referred to medical	· · · · · · · · · · · · · · · · · · ·			26. Place of Dea	1 ☐ Yes		Yes 2□No
	Physiclen: r this certifica ral director, I	P.	1 165 2 10		□ ER/Outpatien		4 🗆 Nursing 🗆	ome 5 Resid	dence 6 Other ((Specify)
ono	ttending P death. tor: After t the funera	tlon:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injur Wor M 1 □	yat k? Yes 2 □ No	28d. Describe I	how injury occurred	
Division of	or A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecity)		_	28f. Location (S City or Tox		or Rural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical O	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my lier: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the tir restigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manne date and place, and	ar as stated. I due to the cause(s)
,	To the within To the comp	ž	29b. Signature and title of certifier	MD		29c. Licens	e number		29d. Date signed (A	
	Ω		Name and address of person who col	moleted cause of death ()	tem 23a) (Tune	Print)	18184		6/30/0	
_	2		Elhamy Eskan	1000 112	50 l	W 7th	Street	Frederic	K, MD	21701
ì	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 1	2005 Registrate's Signature	gnature #	fred!		-		

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Maryland /		ent of Health			iene	23393
	Physicia		1. Decedent's Name (First, Middle, Last)				2.	Date of Deat Month		3. Time of Death
	/Medic		EDWARD REESE	HENDRICKSON		0. T	(07	08 200	19:50 M
	Examin	er	4a. Eacility Name (If not institution, give st.	reet and number)) 4b.	City, Town, or Location	n of Death	1	4c. County of Dea	ath
	Funeral		5. Social Security Number 6. Sex	7. Age (in yrs. last		nder 1 Year If Under	er 24 Hrs. 8.	Date of Birth (Month, Day,	Year) 9. Bin	hplace (State or Foreign
	Director		215-12-2563	M 2□F 84	Yrs.	Itils Days Hours		EB. 5,		rountry) RYLAND
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location					10d. Inside City Limits
	Mary a-f sh	ţo	MD ALLEGANY	CUME	BERLAND					1∭Yes 2□No
	ith the	Director	10e. Street and Number		10	f. Zip Code		1	0g. Citizen of What C	ountry?
	s 23a		701 FURNACE STREET			21502			U.S.A.	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel; or Items 23a or 28a-f show aumatic event, the Medical Examination at retilied at	by Funeral	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII		Decedent of Hispanic Cospecify Cuban, Mexicons 2 No Specify		y Yes or No- an, etc.)	14. Race - Am Black, Whi	
Š	2 hou		15. Decedent's Educa	ation 16		Usual Occupation			16b. Kind of Business	
21	ithin 7 18. 18. "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	of work done during mo OT use retired)	ost of working	,		RINGFIELD
2	filed w Hygier Sther th		17. Father's Name (First, Middle, Last)		TIRE	BUILDER	thada Nama //	Tiron Adiabation A	TIRE COM	PANY
Maryland 21215-0036	should be find Mental Finarked of	To Be	SAMUEL REESE HENDE			E	DITH H	HAUSE	Maiden Sumame)	
<u>a</u>	ges 1 and 2 should nt of Heath and Men if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type: LLOYD F. HENDRICKS			ress (Street and Num. CMULLEN HW				
	s 1 and 2 (Health Item 27 other tra		20a. Method of Disposition	20b. Place	of Disposition	The Control of the Co	Date	-	20c. Location - City or	
timore,	Pages nent of int: if its iry or o		Durial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)			RIAL PARK	07/11/2	2005	CUMBERLA	ND, MD
Balti	permit. Page Department of important: If any injury or once.		21. Signature of Funeral Service License.	1	22. Nan	ne and Address of Fac CHURCH FUN	- cility FRAT. HO	OMF. P	Δ	
	20E = 3		Grand 41.	Upc hurch	20	2 GREENE S'	TREET	CUMBET	RLAND, MD	21502
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final						est,	Approximate Interval Between Onset and Death
п	Physician /Medical		disease or condition resulting in death)	NON - SMA Due to (or as a consequence		ELL CA	12CIN	AMC		2 mos
L	Examiner		Sequentially list conditions, b.							
	pe tis	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):					
	be executed sician and burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a consequence	ce of):			· -		
8760	cate be executed bhysician and the burial-transit	dlcal E	d.							
9	ng phy	Medi	IF FEMALE:							
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 	ath 3□Ecto	bic pregnancy			23d. Date of de Month	livery Day Year
o.	that the de ed by the a detached f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	i 5∐ Othi	r (specify)				,
ري م	The law requires that the death certific Ite has been signed by the attending p age 2 should be detached for use as	by Ph	Part II. Other significant conditions conti	ributing to death but not resulting	g in the underly	ing cause given in Part	t I.	23e. Did tob	acco use contribute to	o the cause of death?
Srd	v require been sig should b							1 🗌 Ye	es 2⊡No 3□P	robably 4 🗆 Unknown
Records,	e law requ has been je 2 shoul	Completed						24a. Was ar autops		utopsy findings available completion of cause of
								perform	ned? death?	s 2 No
Viita	ysicien: is certific director,	o Be	25. Was case referred to medical examiner?	espital: 1 Inpatient 2 FR/	Outpatient 3	Other	ce of Death (C			
ס ר	g Physier this	\vdash	27. Manner of Death		b. Time of Injury	28c. Injury at Work?			nce 6 Other (Spe ow injury occurred	эспу)
Sio	ttending F death. ctor: After y the funera	atlo	1 Natural 5 Pending 2 Accident investigation	(month, buy rour)	N	1 Yes 2	□No			
Division of	i or Attene after deati Director: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, fa	ctory, office	28f.	Location (Sti City or Town	reet and Number or R I, State)	ural Route Number,
		ā	29a. Certifier 1 Certifying Physi	cian: To the best of my knowled	dge, death occ	rred at the time, date a	and place, and	due to the ca	ause(s) and manner a	s stated.
	To the Hoscita within 24 hours To the Funeral completely filled	ledic	one)	er: On the basis of examination and manner stated.	and/or investig	ation, in my opinion, de	eath occurred a	at the time, da	ate and place, and due	e to the cause(s)
	To	Σ	29b. Signature and title of certifier	O K		29c. License number			9d. Date signed (Moni	
4	HIVA		30. Name and address of person who com	npleted cause of death (Item 23:	a) (Type Brief)	9-148	4 5	A	J4LY /1	2005
7	nds		Dr. Polistian	S. Carrera.	JA -	20 Memo	orial t	HUP,-1	omberla	14 2005 NO MI 21502
	Sta Registr		31. Date filed (Month, Day, Year)	3. Registrar's Signatur	bout	,				
		ar I	1111 1 6 2003	A. R. A. S.	10					

		Í	1- For Amend Items 25,27,28a-f per ME 6848,10/04/05df	1		0.5	23394			
Physicia		an	1. Decedent's Name (First, Middle, Last) William Edward Henry	2. Date of De Month July	Day_ Year		11:00 A M			
	/Medic		William Edward Henry 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	Dury	uly 9 2005 11:00					
	Examin	er	Calvert Memorial Hospital Prince Frederick			vert				
	Funeral Director		5. Social Security Number 235–32–6937 6. Sex 122M 2 F 80 Yrs. Fl Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da July 5	rth ay, Year) 1925	9. Birthi Cour Mary	place (State or Foreign Tand			
	and w	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pepartment of Heatth and Annual Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be nutilised at once.		WV. Mineral Keyser				1 ☐ Yes 2 No			
		Funeral Director	10e. Street and Number Rt. 4, Box 61 10f. Zip Code 26726		10g. Citizen of United		•			
036		Be Completed by	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Specify Specify Cuban, Mexican, Puerto If Yes, Sive Year or Dates:	pecify Yes or No Rican, etc.)	Bla	ce - Americk, White, fy: Whi	etc.			
Baltimore, Maryland 21215-0036			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Paper Maker	orking 16b. Kind of Business/Industry Paper Manufacturer						
and 21			12 17. Father's Name (First, Middle, Last) 18. Mother's Nam Arthur Edward Henry Rosali			me)				
Maryla	12 should h and Mer 7 is marke raumatic	T	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur	ral Route Numb	er, City or Town					
ė,	1 and Health em 27		20a. Method of Disposition 20b. Place of Disposition (Name of	Ince Fr	20c. Location					
timor	Pages tment of tant: If it fury or o		• A ☐ Donation 5 ☐ Other (Specify) *A ☐ Donation 5 ☐ Other (Specify) *A ☐ Donation 5 ☐ Other (Specify) *A ☐ Donation 5 ☐ Other (Specify) *A ☐ Donation 5 ☐ Other (Specify) *A ☐ Donation 5 ☐ Other (Specify) *A ☐ Donation 5 ☐ Other (Specify))	Keyser,	West	Virginia			
Bal	permit Depart Import any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Box 111 Church St., We.				21562			
	Physician /Medical Examiner be executed bhysician and physician and the pnial-transit the pnial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition a							
F 8760,		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	14		se				
17 89	ntificate ng physi as the	Medi	IF FEMALE: 230 If we suppose of programs o	D BY MEDICAL E	XAMINER					
O. Box	The law requires that the death cerate has been signed by the attendir page 2 should be detached for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown			ate of deliver	ery Day Year			
J 9			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use con	tribute to t	ne cause of death?			
4 5		ed t	Acute Subdural Hematoma, Pheumonice	1 🗆	Yes 2 ☐ No	3 🗌 Prot	ably 4 Unknown			
7a K Reco		Completed by	Metastatic prostate concer. Gangrene Food Atrial Fibrillation Deep very thrombosis	24a. Was auto perfo 1 Yes	an 24b. psy prmed?	Were auto prior to co death? 1 \(\subseteq Yes	psy findings available mpletion of cause of			
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T. Fo	hys this al dii	10			idence 6 Oth		γ)			
₹ 200	ding h. After fune	tion	27. Manner of Death 1	Unknow	how injury occui	rrea				
(70%) Divisi	Hospitai or Atte 4 hours after de Funeral Directo ely filled in by th	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To	Street and Numi wn, State)	ber or Rura	il Route Number,			
The state of the s		edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the	cause(s) and m	anner as s and due to	ated. the cause(s)			
	To the I within 2: To the I complet	Me	29b. Signature and title of certifier 29c. License number D 50653		29d. Date signe		Day, Year)			
1	AVA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAW . C.	SURAN	3.9	-				
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature							

,	•		State of Maryland / Dep	eartment of Health and Mertificate of Death	lental Hygie	•					
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last) Helen Evelyn Haetler 4a. Facility Name (If not institution, give street and number)	2. Date of Death Month June	Day Year 26 2005 2:27 p M						
			3024 Steamer Run Road	Cambridge		Dorchester					
	Funeral Director		5. Social Security Number 212–38–4740 6. Sex 1 M 20F 66 Yrs. Usual Residence of Decedent	8. Date of Birth (Month, Day, Y Aug 8,	year) 9. Birthplace (State or Foreign Country) Mary Land						
	with the Maryland e or 28e-f ehow	tor	10a. State 10b. County 10c. City, Town or L Maryland Dorchester Cambrid	10d. Inside City Limits 1 ☐ Yes ঽৄৢৢৢৢ No							
5	or 28e	Jirec	10e. Street and Number	100	g. Citizen of What Country?						
3	ath w 8 23e	ral	3024 Steamer Run Road	21613		US					
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygjene. Importants if item 27 is marked other then "neturel; or items 23e or 28e-1 ehow may injury or other treatmetic event, it is Marical Exercinet must be notified at ance.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ○ Wildowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ○ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
	vithin 72 hanne. hen "netu e Madical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ing 16	16b. Kind of Business/Industry						
d 2	filed v Hygie other t		12 Li 17. Father's Name (First, Middle, Last)	ne Worker	(First, Middle, Ma	Electronics Mfg					
lan	should be nd Mental marked o	To Be	Harry Franklin Sample	Lillia		addir darramoy					
lary	2 shou and N is mai		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rura		City or Town, State, Zip Code)					
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre ance.		Charles W. Haetler, Jr Son 3726	Green Point Road							
JOre	ages 1 nt of H : If ite			matory`or other place)		c. Location - City or Town, State					
Itin	artmer ortent Injury		The state of the s	orial Park 7/2/ 2. Name and Address of Facility	05 (Cambridge, Maryland					
Ba	Depa Depa Impo eny ir		1 1 1 T	homas Funeral Home	, P.A.	Marriand 21612					
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Acuart - Hermorhagic								
l Records, P.O. Box 68760,	Examiner	edical Examiner	d								
	es that the death certific igned by the attending p be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 { 4 ☐ Pregnant at time of death 5 { 9 ☐ Unknown		23d. Date of delivery Month Day Year						
	w requires that been signed be should be det	by	Part II. Other significant conditions contributing to death but not resulting in the temperature.	inderlying cause given in Part I.		bacco use contribute to the cause of death? es 2 \(\subseteq \text{No} \) 3 \(\subseteq \text{Probably} \) 4 \(\subseteq \text{Unknown} \)					
	icien: The law re certificate has be ector, page 2 sho	Completed	The II OM		24a. Was an autopsy performer						
Vital	sicien certif rector	o Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death							
ō	Attending Physicien: The Ir death. sctor: After this certificate haby the funeral director, page	\vdash	27. Manner of Death 1	- Indiana and	ne 5 🗹 Residenc 28d. Describe how	e 6 □Other (Specify) injury occurred					
Division	or the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)					
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my knowledge, deal 2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurre	and due to the caused at the time, date	e(s) and manner as stated. and place, and due to the cause(s)					
•	with To I	Σ	29b. Signature and title of certifier MO	29c. License number D57290	29d.	Date signed (Month, Day, Year)					
				D3 A Muir St. (Cembridge	, MO 21613					
	Sta Registr		31. Date filed (Month, Day, Year) JUL U 1 ZUU5 32, Registrar's Signature								

		1 - For State	State of Marylar		artment of F			iene	በበሮ	200	0.0	
		Registrar 1. Decedent's Name (First, Middle, La	st)	00	Tuncate of	Dealli	2. Date of Deat	h		3. Time of	Death	
Physi			Michael Irela	nd, Sr			June 30	, ^{Day} 0	05 Yeer		Ам	
/Med Exam									4c. County of Deeth			
		11330 H. G. Trun	nan Road			sby			Calvert			
Funera			Sex 7. Age (In yrs.	lest birthday; Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Dey,	Year)		irthplece (State o	r Foreign	
Directo	or	Usual Residence of Decedent	64	113.			Feb 26	, 19	41 Wa	shingtor	1, DC	
yland		10a. State 10b. County	10c. C	ity, Town or L	ocation					10d. Inside C	ity Limits	
e Mar	ctor	MD Charle	es l	Waldor	f					1 🗆 Yes	2 √ No	
CLINISTED SOURCE With the Maryland filed within 72 hours after death with the Maryland Hygiene. Sther then "natural", or Items 23a or 28a-1 show ont, the Medical Example multipe notified at	Funeral Director	10e. Street and Number			10f. Zip Code	602	1	0g. Citize	n of What C	Country?		
s 23s	era	908 Sloan Avenu					Decity Ves or No.	14	USA	nericen Indian,		
fter de	Fun	1 Never Married 2 Married	Armed Forces? 1 Sayes 2 □ No If Yes, Give	Forces? If Yes, specify Cuban, Mexican, Puerto			o Rican, etc.)	lican, etc.) Black, White, etc.				
ours a	b	3 Widowed 4 Divorced	1 ☐ Yes 2X No Specify:					Specify: White				
72 hc	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	edent's Usual Occup a kind of work done DO NOT use retired	ation during most of wo	rking	16b. Kind	of Busines	s/Industry		
within han	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired Line Local			Flo	otni o	Down		
filled withi Hygiene. other there		17. Father's Name (First, Middle, Last	')		Tille Loca		ne (First, Middle, M			Power		
should be fill and Mental Hy marked oth	To Be								Carregher			
2 shou and N is mail		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street		ıral Route Number	City or T			,	
end ealth		Earl Ireland (so			H.G. Tr	ueman Roa	100	-		•		
Daltimore Dermit, Peges 1- Department of He mportant: If item		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	cemetery, cre	osition (Name of matory or other place		7.6			or Town, State		
t. Per thmen thant:		'4 □Donation 5 □ Other (Speci	77		et Cem.	20	005		ington		5.0	
Daltimor permit. Peges Depertment of I Important: If its any Injury or or	once	21. Signature of Funeral Service Lice			2. Name and Addre							
Harris		23a. Part1. Enter the disease, shock, or heart failure. List only	plications that caused the dea						60	Approximat		
Physicia: /Medica	_	Immediate Cause (Final disease or condition resulting in death)	a. Metast	atic	Pro.					Interval Bet Onset and		
Examine	_			Due to (or as a consequence of): Due to (or as a consequence of):								
	je je	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	b. Due to (or as a conse									
ecuted and transi	Examiner	Cause (Disease or injury that initiated events c.										
ate be executed hysicien and the burial-transit	cal E	Due to (or as a consequence of):										
ob/ ificate g physias the	-											
× end on se	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c If yes outcome of pregnancy						23d. Date of delivery Month Day Year			
death death de atten	Icla	in the past 12 months? 1 Ves 2 No. 1 Ves 2 No. 1 Other (specify)										
at the Stacker	hys	9 🗆 Unknown	9⊡ Unknown					1				
VITAI MECOTIS, P.O. ician: The law requires that the certificate has been signed by the rector, page 2 should be detache	b								co use contribute to the cause of death?			
law requi	eted								2 No 3 Probably 4 ⊠Unknown			
The law rate has be page 2 sh	ompleted	Httrial H	brillation				24a. Was a autops perforr	v I	24b. Were a prior to death?	autopsy findings completion of c	available ause of	
VICAL HO	ပိ	OF Man case referred to medical					1 ☐ Yes 2	P No		s 2 No		
Of VICA Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	TER/Outnatie	ont 3 DOA Oth		ath (Check only on		Other /Sr	acifu)		
	ı.	Temparent September 1997										
VISION Attending r death. ector: After by the fune	atlo	2 Accident investigation M 1 Yes 2 No										
- 9	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street a building, etc. (Specify)							and Number or Rural Route Number, te)			
pital ours a eral	S	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
24 hc 24 hc Fun etely	edical	(Check only one)	miner: On the basis of examin and manner stated.	ation and/or in	nvestigation, in my o	me, date and place opinion, death occi	e, and due to the caured at the time, d	ause(s) ar ate and p	ace, and di	as stated. Le to the cause(s	i)	
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	₹ S	29b. Signature and title of certifier / 29c. License number 29d. (9d. Date :	Date signed (Month, Dey, Year)			
		lyan	· c ma		D.	5065	3	7		2005		
12		30. Name and address of person who		m 23a) (Type	Print) GY	ANC	SUR,	ANI	9			
12		5851 - Deo 31. Date filed (Month, Day, Yeer)	32. Registrays Sign	1400	Road	Dec	ule	m.7	>, ;	2075)	
	State strar		6 2005	. K	Coast &							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 26, **Physician** Emery Allen Johnson 8:13 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner National Naval Medical Center 9. Birthplace (State or Foreign Bethesda Hours Min. April 16, 1929 South Dakota 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days **Funeral** 1(**X**)M 2□ F 469-30-1890 76 Yrs. Director Usual Residence of Decedent flied within 72 hours efter death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ▼ No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13826 Dowlais Drive 20853 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 → Married 1 ☐ Yes 2 No Specify White Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Public Health $5\pm$ Physician other Service injury or other traumatic event, permit. Pages 1 and 2 should be flike Department of Health and Mental Hy Important: if Item 27 is marked other any injury or what traument 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur Emery Albert Johnson Florence E. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13826 Dowlais Drive, Rockville, MD 20853 Nancy Johnson/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Fort LincolnCrematory July 2, 2005 Brentwood, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral and 21. Signatore of Fureral Service Licensee Cremation Center, 1040 Rockville Pike, Rockville, em our or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onse and Death Immediate Cause (Final disease or condition resulting in death) Physician adenocaranoma 201 1 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Illinknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? res 2 2 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deatn (Check only one Hospital: Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 2 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 ENatural 5 Pending Injury 1 Yes 2 No investigation death 2 Accident Diractor: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical nes-stated 29b. Signature and 29d. Date signed (Month. Dey, Year) 01 010173548 01 WISCONSIL completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, L

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

34 Registrar's Sign

			For State Registrar 1. Decedent's Name (First, Middle, Last)	ate of Marylan		tificate				Reg. I		15	233	98
	Physici		Ronald A. Johnson	n Jr.					2. Date of Month)a y 5	2 ^Y 865	3. Time o	of Death)4A _M
	/Medic Examir		4a. Facility Name (If not institution, give stree John Hopkins Hosp:					Location of D More			4c. County N/A	of Death	1	
	Funeral Director		5. Social Security Number 219-98-4112 6. Sex Usual Residence of Decedent	7. Age (In yrs. 2]		If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. Date of Month, Feb.	Birth Day, Yes	968	9. Birthp Cour Mar	vlace (State Try) ylan	or Foreign d
	e Maryland ia-f show	ctor	Maryland Anne Arun		y, Town or Lo							1	10d. Inside C	City Limits
	th with th	Funeral Director	10e. Street and Number 102 West Washingt	on St.		10f. Zip	Code 1401			10g. (Citizen of V USA	What Cour	ntry?	
036	d within 72 hours after death with the Maryland plane. Jen. Than "natural", or Items 23a or 28a-f show the Madical Examiner must be multiled at the Madical Examiner.	by	XXNever Married 2 Married 1	Vas Decedent Ever in U immed Forces? □ Yes 2 M No Yes, Give ear or Dates:	11	Vas Deced Yes, spec			? (Specify Yes or uerto Rican, etc.)	No-	Blac	e - Americk, White,		
1215-0	within 72 ho ene. than "natur ne Madical	Completed		ollege (1-4or 5+)		kind of wor OO NOT us	k done d e retired)	uring most of	working		Kind of Bu			
0	be filed tal Hyg od othe event,	Be	12th 17. Father's Name (First, Middle, Last) Ronald A. Johnson	lyr	Un	it S	ecre		Name (First, Midd	lle, Maid			<i>1</i> e	
aryli	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev	T _O	19a. Informant's Name/Relationship (Type, F		19b. Mailin	g Address	(Street a		r Rural Route Nun			State, Zip	Code)	
σ	os 1 and 2 of Health of item 27 i		Barbara Harris (Mo 20a. Method of Disposition		_				Annapo	_	Location -			
Baltimore,	Pages nent of I int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State Be	Place of Dispos ਵਾਦਾਉਣਾਦਾ Pa		modeci	9a1¦ 6-	30-05				, Md.	
Rall	permit. Pages Department of I Important: If its any njury or o		21. Signature of Funeral Service Licensee Lavry B, A	esa MOOS	83 8 W	Name and M. Re 21 We	Addres eese	s of Facility & SC St. A	ns Mort	uar	-			
I,	nysician /Medical		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	ns that caused the death use on each line.	h. Do not ente	or the mode	of dying	such as car	diac or respiratory	arrest,			Approxima Interval Be Onset and	tween
.09	Examiner lician and prival-transit	Ical Examiner	Sequentially list conditions, if any, leading to intrinsolate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a conseq	uanca oi). +ens	cor		· \$	mellel				>10	year
Box 6	death certific e attending p id for use as	Physician/Med	in the past 12 months?	yes, outcome of pregna □Live birth 2 □ Feta □ Pregnant at time of d □ Unknown	Ideath 3	Ectopic pre					23d. Dat	e of delive	-	Year
rds, P.	sign d be	by	Part II. Other significant conditions contribu	ting to death but not res	ulting in the un	derlying ca	iuse give	n in Part I.			/		ne cause of o	
l Rec	The law ate has b page 2 s	Completed	-							topsy rformed?	, P	prior to con death?	psy findings mpletion of d	available cause of
n of	ng Physician Mer this certifi Ineral director	ion: To Be		tal: 1 Inpatient 2 Sa. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28	Bc. Injury Work	r: 4 □ Nursir at ?	Death Check onling Home 5 Re 28d. Describ	sidence			1)	
Division	To the Hospital or Attending within 24 hours attended in To the Funeral Director: After completely filled in by the funeral completely fil	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	Be. Place of Injury - At he building, etc. (Specify	ome, farm, stre	M eet, factory,		'es 2□No	28f. Location City or 7	(Street own, Sta	and Numbi ite)	er or Rura	l Route Nun	nber,
	e Hospita 24 hours e Funeral letely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medicel Exeminer:	n: To the best of my kno On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred a estigation,	at the tim in my op	e, date and p inion, death o	ace, and due to the	e, date a	(s) and ma ind place, a	nner as st and due to	ated. the cause(:	s)
	To th withir To th compi	Me	29b. Signature and title of certifie	en e	>	1	License	number 284 °	3		Date signed			
_			30. Name and address of person who comple	11 - 1	n 23a) (Type, 1		22	Bo	5100	m D	2	071	<u>_</u>	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 9 200	32. Regionar's Signa		A.	2 -							

DHMH 17 Rev 1/2001

			For State Registrar	State of N	Maryland / D	epartme			and M	_	_	2005	23	300
			Decedent's Name (First, Middle,	Last)		001111101	210 01 1	J04111		2. Date of De	Reg. No	<u>a. 0 0 0 0 </u>	3. Time	of Death
н	Physici			Charle	s Johnso	'n				Month June	24	ay Year 2005		
	/Medic Examin		4a. Facility Name (If not institution,				ity, Town, or	Location of	f Death	<u>o une</u>	-	c. County of Deatl	<u> 5:3</u>	5 a "
	Examin		Chesapeake Ho	spice Ho	use		nthi				A	nne Aru	nde1	
	Funeral			S. Sex 7. /	Age (In yrs. last birtl	hday) If Un	der 1 Year	If Under 2		8. Date of Bir (Month, Da				e or Foreign
ь	Director		233-34-8668	1 ∑ M 2□F	82 Y	rs. Month	ns Days	Hours	Min.	Nov.	10	1922 W.	va .	
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	as I postion								
	sho	5	Toa. State		roc. City, Town	OI EOCALION							10d. Inside	es 2 No
	the N	ect	Maryland Anne 10e. Street and Number	Arundel	Glen B						10- 0			
	with a or	Funeral Director		2 TT 2			Zip Code	_			rog. Ci	itizen of What Co	intry?	
	leath	era	201 North Cra	12. Was Deceder		3P	2106		nin? (Spe	cify Yes or No	- 1	14. Race - Amer		
(0	r Iten	Fun	1 ☐ Never Married 2½ Marrie	Armed Force d 1 ☐ Yes 2 5	s?	If Yes, s	pecify Cuba	n, Mexican,	Puerto I	cify Yes or No Rican, etc.)		Black, White	, etc.	
8	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	~	1 🗆 Yes	3 2√□ No	Specify:				Specify: B1	.ack	
21215-0036	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show disal Examiner must be molified at	Completed	15. Decedent's (Specify only highest			Decedent's U (Give kind of			of working	na	16b. K	Kind of Business/I	ndustry	
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	filed w Hygier othar ti	S	12th	0			Barb				US	Nava1	Acad	emy
and	be fi	Be	17. Father's Name (First, Middle, La							(First, Middle,				_
ž	2 should be and Mental la markad (2	Harvey Joh		104	Mailtan Add	/011					tainab1		
Maryland	nd 2 sl alth an 27 la r ir traur						Glei	n Bur	nie	. Mars	/1 at	or Town, State, Zind. 21.06	p Code)	
	1 a Te		Marion Johnso 20a. Method of Disposition	n (wire)	20b. Place of I	Disposition //	Vame of	rain	HIG	hway /	ADT.	. 3P .ocation - City or 1		
Baltimore,	Pages nent of f ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		te cemetery Hill	Crost		1	. 6/	20 /05				
Ė	nit. Partme ortan injur		21. Signature of Funeral Service Li		111177	22 Name	and Addres	s of Eacility	821	West	St	nnapoli • Annap	S, Mo	o. Md
Ba	permi Depa Impo any ir	·	Jan H. A	2. 40 MOO	487							y, P.A.		1401
			23a. Part1. Enter the disease, or c	omplications that caus	ed the death. Do no							2 / 1 0110	Approxim	ate
l.	Prhysician		shock, or heart failure. List or Immediate Cause (Final	nly one cause on each	Ine.	1	0	11	. (W			Interval B	etween d Death
	/Medical		disease or condition resulting in death)	a Due to (or a	as a consequence of	0:	120	5/5/4		Arct			(D) 11	لد
Н	Examiner		Constant line and distant	b	Visita	2 (0	ne49						12 (1	C.
	n =	ner	Sequentially list conditions, if any, reading to intrinsical cause. Enter Underlying Cause (Disease or injury		is a consequence of	ŋ.						- 9	- 43	
	acute ind trans	Examiner	that initiated events	с										
ő,	ate be executed hysician and the burial-transit	E	resulting in death) Last	Due to (or a	is a consequence of	f):								
8760,	cate be executed physician and the burial-transit	by Physician/Medical		d										
9 ×	death certifics e attending pl id for use as t	/Me	IF FEMALE:	23c. If yes, outcom	ae of pragnancy									
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 □Ectopio						23d. Date of delive Month	ery Day	Year
o.	0 0 0	ysl	1 Yes 2 No	9□ Unknown		3 L Olinei	(Specify)							
٥.	that the ned by detac	y Pt	Part II. Other significant condition	s contributing to death	but not resulting in	the underlying	g cause give	n in Part I.		23e. Did to	bacco	use contribute to	the cause of	f death?
rds,	The law requires that the site has been signed by the bage 2 should be detache									1 □ Y	'es 2	No 3□ Pro	bably 4	Unknown
Record	law requir as been s 2 should	ompleted								24a. Was	an	24b. Were aut	opsy finding	s available
	hysiclan: The lav nis certificate has I director, page 2	mo .								autop	rmed?	death?	in noiseliama 2 X 1 No	cause of
Vital		BeC	25. Was case referred to medical					26. Place of	of Death	(Check only of	2 No ne)	(%)	100 a ki	
	Physiclan: this certificatal director,	ToE	examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 ER/Out	patient 3	DOA Othe	4 🗆 Nurs	sing Hom	ne 5 Resid	lence	6 Other (Speci	m) Hon	m Health
D C	ng Pi	on:	27. Manner of Feath 1 █Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Tir Day Year) Inj	me of ury	28c. Injury Work	at ?	2	8d. Describe h	ow inju	ry occurred	0	2 1-0-1-2
s S	Attanding or death. actor: After by the fune	catl	2 Accident investiga 3 Suicide 6 Could no	t he		М		′es 2□N	-					
Division of	l or Al after o Dirac I in by	Certification;	4 Homicide determin	286. Flace of t	njury - At home, farr etc. <i>(Specify)</i>	n, street, fact	ory, office		2	8f. Location (S City or Tow	itreet ar m, State	nd Number or Rur e)	al Route Nu	ımber,
	spital ours sours sours sours sours sours sours sours illed	S S	29a, Certifier Certifying	Physician: To the bes	et of my knowledge	death occurr	ad at the tim	0 data and	Lalana a			\		
	To the Hospital or Attanding Ph within 24 hours atter death. To the Funeral Diractor: After th completely filled in by the funeral	edical	(Check only 2 Medical E)	aminer: On the basis and manner:	of examination and/	or investigati	on, in my op	inion, death	n occurre	d at the time,	date and	d place, and due t	o the cause	o(s)
	To th withir To th comp	M	29b. Signature and title of certifier		h	2	9c. License	number			29d. Da	ite signed (Month,	Day, Year)	-
}			1//20	- OS	e	>	03	15%	~/		10	ne 28	700	5
			. Tame and address of person wi	completed cause of	death (Item 23a) (T		31 /	1		11 0			101	1
			31. Date filed (Month, Day, Year)	20 1 mm 3	trar's Signature	400) Hill	WIN	y 0	Jen S.	an	1/42 2	100/	/
	Sta Registr	- 200	JUN 2		Server M	An	A.		•				-	

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma		Depa		Health a	and Me	ental Hyg	_		221	0.0
			Decedent's Name (First, Middle, Last)	')						2. Date of Dea	th		3. Time of	Death
п	Physici /Medio		Edith Emma Jo	nes						July	9^{Day} 20	0 5 ear	3:35	Рм
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town					y of Death		
4			Long View Nursi					heste				roll		
in the same of the	Funeral Director		107 10 0405	7. Age	99	Yrs.	If Under 1 Yea Months Day		Min.	B. Date of Birth (Month, Day Aug. 22,	1905	Cou	place (State of ntry) yland	_
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside Ci	ity Limits
	Manyl f sho	ō	MD Carrol	1	Man	cha	ster						1 🗌 Yes	2 X No
	r 28a	Director	10e. Street and Number		11411	OHC.	10f. Zip Code			1	0g. Citizen of	What Cou	ntry?	
	h with		3332 Main Str	eet				21102			U.S	.A.		
	deal	by Funerai	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. \	Was Decedent of 1 Yes, specify Co	Hispanic Ori	gin? (Spec	ify Yes or No- ican, etc.)		ce - Ameri		
90	or It	F	1 Never Married 2 Married	1 ☐ Yes 2 📉 N If Yes, Give	40		1 ☐ Yes 2 🛣 N			, ,	Speci		nite	
Ö	hours ural',	q p	3 Widowed 4 □Divorced	Year or Dates:	14	Ga Dasse	dentis Hevel Oss			1				
7	in 72	Completed	15. Decedent's Edu (Specify only highest grad	de completed)		Give (Give life. l	dent's Usual Occ kind of work dor DO NOT use reti	upation ne during mosi red)	t of working	7	16b. Kind of E	ousinessym	idustry	
72	iene.	mo du	Elementary/Secondary (0-12)	College (1-4or 5	+)		orer	,			Plast	ics		
ğ	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "natural", or Items 23a or 28a-f show event, it a Modral Examiner must be multired at	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	ers Name (First, Middle, i	Maiden Suma	me)		
<u>a</u>	uld be Aenta rked tlc ev	To B	George H. McCo	omas				Mar	су Ја	ne Ma	rtin			
any	sho and h	1 3	19a. Informant's Name/Relationship (T)				ng Address (Stre							
Baltimore, Maryland 21215-0036	and sealth m 27		Beatrice A. Turnbar	ugh/Daught			Main	St.,						
ore	ges 1 t of H if ite or otl		20a. Method of Disposition 1 N Burial 2 □ Cremation 3 N F	Removal from State	New	or Uispo Hery, cren Fre	sition (Name of natory or other p eedom	lace)	$\mathtt{July}^{^{\mathtt{Da}}}$	15.	20c. Location			
ţ	t. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify)		Cei	mete	ery		2005		New Fre		•	Tna
Bal	permit. Pages 1 and 2 should be lited within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, it a Modical Examiner must be notified at once.		ames . I	vertens	eint	71.	Name and Add						1734	19
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that caused one cause on each lin a.	the death. D	o not ent	er the mode of d	ying, such as	cardiac or	respiratory arr	est,		Approximat Interval Bet Onset and I	ween Death
ı	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):								
1	be sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a cons y ueno	ce of):							/	
٧	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequenc	ce of):								
760,	e be e /sician e buria	calE		ď										
89	ifficate g phy as the			<u> </u>										
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medi	in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea	ath 3□	Ectopic pregnar Other (specify)					ate of delive		Year
P.0.	at the d by ti letach	Phy	9 Unknown Part II. Other significant conditions co		ut mat sacultin	— in the	adach dan an da	outen in Cont I		22a Did to	bacco use con	stributo to t	ha agusa of d	loath?
Vital Records,	w requires that been signed I should be det		Part II. Other significant conditions co	nitributing to death bi	ut not resulting	g in the ui	nderlying cause	given in Pait i.		1 🗆 Y		-	pably 4 🗆	
eco	ne law re thas bei ge 2 sho	Completed								24a. Was a	V	Were auto	opsy findings impletion of c	available ause of
H		Con								perfor	ned?	death?	26 No	
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						of Death	Check only on	re)			
	Physician: r this certific ral director.	မ	1 Yes 2 Ne	Hospital: 1 ☐ Inpatie		Outpatien	3 DOM			e 5 Reside			fy)	
uc.	Jing F	ion	27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injur (Month, Day		b. Time of Injury	W	ork? ☐ Yes 2 ☐ i		3d. Describe ho	ow injury occu	rred		
Division of	death.death.ctor: A	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	urv - At home.	, farm, str				3f. Location (Si	reet and Num	ber or Run	al Route Num	ber,
<u>S</u>	s after s after al Direct	Certification:	4 Homicide determined	building, etc	c. (Specify)		,			City or Town	n, State)			
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai (/sician: To the best of iner: On the basis of and manner sta	examination									;)
	To th withir To th comp	Me	29b. Signature and Alle of certifier					nse number			9d. Date sign	ed (Month,	Day, Year)	
			▶ \\\X\\				1	33		1	710	105		•
	1	1	30. Name and addr s of person who c	ompleted cause of d	eath (Item 23	a) (Type,	Print)		P:	1, 1	-0	-,6	W271	
	V			~1≥ W	Her	Ö	× 111+/c	mo sar	- 1 \	ee o	low for	ر ا	مرد ۱۱	014
	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 6 21		ar's Signature		marks				•			-

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State Registrar	aryland / Depa <i>Cei</i>	artment of H rtificate of L		, ,	iene	5231.02
	Physici /Medi	tal	1. Decedent's Name (First, Middle, Last) Perrin Aloysius		Kent		2. Date of Deat Month June 23	Day 2005	Year 1:00 p M
- OF 12	Examir	ier	4a. Facility Name (If not institution, give street and number) Warm Care Assisted Living 5. Social Security Number 6. Sex 7. Ag	ə (İn yrs. last birthday)	4b. City, Town, or Potoma If Under 1 Year		9. Date of Righ	1	gomery
	Funeral Director		579-05-4786 Usual Residence of Decedent	88 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 29		Birthplace (State or Foreign Country) Kansas
	he Marylan 8a-f ehow culfied at	Director	10a. State 10b. County Maryland Montgomery	10c. City, Town or Lo	nsington				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with t	ral Dire	10e. Street and Number 3620 Littledale Road, Ap	t. 208	10f. Zip Code 2089	5	10	g. Citizen of W	hat Country? USA
980	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow alsea Exer-iliner must be rotified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent I Armed Forces? Y□ Yes 2 □ Mit Yes, Give Year or Dates:	lo	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑No	spanic Origin? (Spen n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		- American Indian, K. White, etc. White
Maryland 21215-0036	d within 72 hogiene. giene. ar than "natur i the Masicel	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5 5 +	+) (Give	dent's Usual Occupa kind of work done d DO NOT use retired, Orney	luring most of working	ng .	I6b. Kind of Bus Internal Service	siness/Industry 1 Revenue
yland	ould be file Mental Hy, arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) William Perrin Kent			18. Mother's Name Elizabe	th Galla	agher	,
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Marical Ever chart be notified at Once.		19a. Informant's Name/Relationship (Type, Print) Mary Louise Kent/ Wife 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	3620 20b. Place of Disponenterry, crem	Littled	ale Road, se Ser	Apt. 20	08, Kens	State, Zip Code) 20895 sington, MD City or Town, State on, Virginia
Balti	permit. Departra Importa any inju		21. Signature of Funeral Service Licens	. f1	rancing Addres 00 Univer:	scallins l sity Blvd	Funeral , W., Si	Home Ir	nc pring, MD 20901
8760,	death certificate be executed e attending physician and e attending physician and idea as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (L'issae or ir jury that initiated events	ive Heart I a consequence of): C Disease a consequence of): a consequence of):		, 300 T	rospiratory arre	34,	Approximate Interval Between Onset and Death 10 Years
O. Box 6	death certif e attending od for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
О.	The law requires that the to have been signed by the bage 2 should be detache	ed by Ph	Part II. Other significant conditions contributing to death but Gangrene, Cellulitis of Rice		nderlying cause give	n in Part I.			oute to the cause of death?
Vital Records,	n: The law re icate has bee r, page 2 sho	Completed					24a. Was an autopsy perform	pri	ere autopsy findings available for to completion of cause of lath?
o	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation; To Be	27. Manner of Death 1 Matural 2 Accident 28a. Date of Injur (Month, Day	nt 2 ER/Outpatien y Year) 28b. Time of Injury	28c. Injury Work	26. Place of Death T 4 Nursing Hom at 28 Yes 2 No	the same of the sa	nce 6 1 Other	
Division	ital or Att urs after de ral Directo	Certification:	4 ☐ Homiciae building, etc				City or Town,	State)	r or Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier (Check only onle) 1 ★ Certifying Physician: To the best of 2 ★ Medical Examiner: On the basis of and manner sta	examination and/or inv	estigation, in my opi	inion, death occurred	d at the time, da	e and place, an	nd due to the cause(s)
)	15TI		29b. Signature and title of certifier Lobel H Blee	M		8556	29	June	(Month, Day, Year) 23, 2005
	17			0 Wisconsi	n Avenue,	#140, Ch	evy Cha	se, MD	20815
\$ () ()	Sta Registr		31. Date filed (Month, Day, Year) 2005	r's Signature	de				

Stauroula χ_a tsetos 049-48-1398 pivision of Vital Records, P.O. Box 68760,

		. For	State of Maryla	nd / Department o		•	•	
		1 - State Registrar		Certificate of	of Death		N2005	23403
Physic /Medi		1. Decedent's Name (First, Middle, Las		itsetas		2. Date of Death Month	Day Jear	3. Time of Death
Exami		4a. Facility Name (If not institution, give			n, or Location of Death		4c. County of Death	
		5. Social Security Number 6. S	ox/ Medical C ex 7. Age (In yrs	last birthday) If Under 1 Y	SDUI 4 par If Under 24 Hrs.	8. Date of Birth	Wicom	ICO
Funeral Director			□ M 2⊠F 8	Adamah - D	ys Hours Min.	(Month, Day, Y	3 . 5	nplace (State or Foreign untry)
yland how		10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
Be-fs	Director	VA Accom	ack C	hincotrague				1 DKYes 2 DNo
with the	D E	10e. Street and Number	0 -0	10f. Zip Cod		100	J. Citizen of What Co	•
ns 23	Funeral	6296 Chrster 11. Marital Status	12. Was Decedent Ever in 1		of Hispanic Origin? (Spe Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - Amer	
or Item		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 KNo If Yes, Give			Rican, etc.)	Black, White	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent; if Item 27 is marked other then "naturel", or Items 23e or 28e-f show supply injury or other treumatic svent, Ite Mudical Examiter, wat its codified at once.	d by	3 ⊈Widowed 4 ☐ Divorced	Year or Dates:	1 ☐ Yes 2 🔀			Specify: W	hite
ed within 72 hours aft giene. er then "naturel", or the Mudical Exam	Completed	15. Decedent's Ed (Specify only highest gra	ducation (de completed)	16a. Decedent's Usual O	ocupation one during most of working stired)	ng 16	6b. Kind of Business/l	ndustry
2 should be filed within and Mental Hygiene. Is marked other then eumatic event, IIIn Manage and the market and the manage and	E D	Elementary/Secondary (0-12)	College (1-4or 5+)	##6. BONO! 230 /	Homema		Self	
e filed al Hyg other	a o	17. Father's Name (First, Middle, Last)	1		18. Mother's Name		uiden Sumame)	
Menta Menta arked aric s	To B	Stauros t	ios malios		Throd	ora G	ianakos	•
nd 2 should be file lith and Mental Hy 27 Is marked oth r treumatic svent		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (St				
1 and 2 Health Health		20a. Method of Disposition		Place of Disposition (Name of	ter Park		hincoteog	
Pages nent of I int; If Its		1 ∰Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif	Removal from State	cemetery, crematory or other	place)		0 1	
permit. Pages 1 ar Department of Hea Importent; If Item any injury or other once.		21. Signature of Funeral Service Licer	100	lood land Cem		6/05 8	tamtord,	C T VA 23331
Depai Impo any ir		I amanda C.	Botto	Salyer	Funeral Home	6327 (Church St.	01.1
Provided and Associated Provid	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	one cause on each line.	equence of):		r respiratory arres	,	Approximate Interval Between Onset and Death
death certifical	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of preging the birth 2 Fersing 4 Pregnant at time of 9 Unknown	tal death 3 □Ectopic pregn			23d. Date of deli Month	very Day Year
8 8 g	d by Pi	Part II Other significant conditions of	contributing to death but not re	esulting in the underlying caus	e given in Part I.		cco use contribute to	
The la The la ate has	Completed by	CONGESTIVE	HEART 7	FAILURE		24a. Was an autopsy performe	prior to d	topsy findings available ompletion of cause of
ysician; This contificate	Be (25. Was case referred to medical examiner?	Liaitali		26. Place of Death	(Check only one)		
Physician; this certific ral director,	2	1 Yes ZX No 27. Manner of Death	Hospital: 1 Inpatient 2 [☐ ER/Outpatient 3☐ DOA 28b. Time of 28c.		ne 5 Residen 28d. Describe how	ce 6 ☐ Other (Spec	eify)
Attending or death.	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury	Work? 1 ☐ Yes 2 ☐ No	Loc. Doscribo non	injury occurred	
크를	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 290 Place of Injury At	home, farm, street, factory, of cify)	fice	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
le Hospitel or n 24 hours afte ne Funerel Dir	ledical C	29a. Certifier 1 Certifying Pt (Check only 2 Medical Example)	nysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, death occurred at the nation and/or investigation, in	ne time, date and place, a my opinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
To the Hc within 24 I To the Fu	Me	29b. Signature and title of certifier	,	29c. Li	cense number	290	d. Date signed (Month	n, Day, Year)
2		Mahren	revit.	NO I	-0060515		6/30/0	5
3,	3	30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, Print)		•	1 1	
~		31 Date filed (Month BANYOR 4		ASTERN SHULE	DR SA	LISBURY	MD 2	1804
St Reais	tate trař	31. Date filed (Month, Jappea 1	2005 Blown	It bout ,				

			1 - For State Registrer	State of Ma	aryland / Dep <i>Ce</i>	artment e <i>rtificate</i>					5	23404
	Physici /Medic		Decedent's Name (First, Middle, Last Lin		KELLEY				2. Date of Death Month July 1,	Day	reer	3. Time of Death
	Examin		4a. Fecility Name (If not institution, give 17322 Gardenwood	Drive		На	gerst			4c. County of Washi	ngto	
	Funeral Director		5. Social Security Number 216-48-1947 Usuel Residence of Decedent	x 7. Ag ∃M 2⊠F	e (In yrs. last birthda 58 Yrs.			Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, June 6,	1947 N	9. Birthp Cour lary	place (State or Foreign http) Land
	Maryland a-f show liked at	tor	10a. State 10b. County Maryland Washingt	on	10c. City, Town or 17322 (ood D	rive			1	10d. Inside City Limits 1 ☐ Yes 2000
	with the a or 284 be not	Direc	10e. Street and Number 17322 Gardenwood	Drivo		10f. Zip (740		10	g. Citizen of Wh		ntry?
960	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "naturel", or Items 23e or 28e-f show important: If item 27 is marked other than "naturel", or Items 23e or 28e-f show playing or other traumatic event, Ita Madical Examiner must be multised at 2006.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			ent of Hispai fy Cuban, M	nic Origin? (Spi lexican, Puerto pecify:	ecify Yes or No- Rican, etc.)	U.S.A 14. Race Black, Specify:	- Americ White,	
21215-0036	within 72 he ane. than "natu te Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 0-11	cation le completed) College (1-4or 5	(Given by the second se	edent's Usual ye kind of work DO NOT use Daycar	done durin retired)	ig most of work	ing 1	6b. Kind of Bus child		,
	12 should be filed within n and Mental Hygiene. 7 is marked other than "reumatic event, Ite Mas	Be Cc	17. Father's Name (First, Middle, Last)			Daycar			e (First, Middle, M	laiden Sumame,)	
Maryland	should the should the	ျှ	Harvey L 19a. Informant's Name/Relationship (7)			iling Address ((Street and	Number or Rura	Atalee	Virgini City or Town, Si		
	and 2 is eelth ar m 27 is her trau		Lloyd C. Kelley -	husband								land 21740
Baltimore,	Pages 1 ment of H ant: If ite ury or otl		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify,		20b. Place of Dis cometery, co Greenlar	ematory or oth	her place)	Jul	2083 W		port	, Maryland
Balt	permit. Departr Imports eny Injs		21. Signature of Funeral Service Licens	11 Jun	mer L4		t Wil:	son Blv		rstown,		ne cyland 21740
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Due to (or as	a consequence of):	70WG	of dying, su	J + C	or respiratory arre	st,		Approximate Interval Between Oriset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):							
O. Box 6	the death certific: y the attending pl ached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetel death 3	□Ectopic pre				23d. Date Mont		ery Day Year
rds, P	w requires that the de been signed by the s should be detached	by	Part If. Other significant conditions co	ntributing to death b	out not resulting in the	underlying ca	use given in	Part I.	23e. Did tob 1 ☐ Ye.			he cause of death?
Vital Records,	The far ate has page 2	Completed							24a. Was an autopsy perform	ned? pri	or to co ath?	opsy findings available impletion of cause of
Vita	ician certife ector	Be	25. Was case referred to medical examiner?	Hospital:	ent 2 ☐ ER/Outpat	ent 3 DO/	Other		h (Check only one		/Snecil	6/1
ion of	ling After une	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		of 28	c. Injury at Work?		28d. Describe ho			<i>n</i>
Division	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	Certification:	3 Suicide 6 Could not be determined	286. Place of in	jury - At home, farm, ic. (Specify)	street, factory,	office		28f. Location (Str City or Town,		or Rura	al Route Number,
	Hospi 24 hou Funer fetely fill	edical			of my knowledge, de of examination and/or ated.							
	To th within To th	Me	29b. Signature and title of certifier	nx	MIS	29c.	License nu	mber (-/-) 8E	29	Od. Date signed	(Month,	Dey, Year)
	Y		30. Name and address of person who c	completed cause of o	death (Item 23a) (Typ	e, Print)	ale	hill	ave	Hage	983	town
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUL 0 5	2005 32. Red	rar's Signature	Speck	,	* * * *			MS	21742

CPM 05-04625 Unpend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Beverly Kroll 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** BEVERLY ALETA PAYNE KROLL July 09 2005 /Medical 17:074a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3821 37th Street Mount Rainier Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 💢 F Yrs Director 219-48-1885 56 20. 1948 Washington, DC Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Examiner must be notified at Directo MDPrince George's Mount Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23a U.S.A. 20712 3821 37th Street by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify. 3 ☐ Widowed 4 ☑ Divorced "natural", White al Hygiene. d other than "nature event, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Hair Stylist Hair Salon 27 is marked other r traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Pages 1 and 2 should be ဥ Thomas Pavne Madge Farleigh John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a:: If item 27 la 1264 Seabright Drive, Annapolis, Maryland Roy A. Kroll, Jr., Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery | 07/15/2005 | Brentwood, Maryland 21. Signalura of Funçal Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland Vallant (har) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate eause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 2 Fetal death Day 4 Pregnant at time of death 5 Cther (specify) ed by the a o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ been si 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy øerformed? at ? 2 No 1 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE 1 XYes 2 ☐ No ٩ 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 XNatural 5 Pending death. М 1 Tyes 2 No investigation after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C the Hospital

1√ Yes 2 No

21409

Year

July 10, 2005

Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2x Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical ICHBCK ONN one) nd tite of certifie 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 1 2 2005

no computed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 CARENLOC 32. Registrar's Signature

OCME

			artment of Health and M		ene g. 2005	231.06
		Hegistrar 1. Decedent's Name (First, Middle, Last)	runcate of Death	2. Date of Death		3. Time of Death
Physic		Charles Raymond Knox		July 7	. 2005	
/Med Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	oury /	4c. County of De	eath
		Dorchester General Hospital	Cambridge		Dorche	ster
Funeral Director		5. Social Security Number 215-20-4926 6. Sex 7. Age (In yrs. last birthday 79 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Feb. 10,		Birthplace (State or Foreign Country) aryland
pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			
death with the Maryland ms 23e or 28e-1 ehow rmust be notified at	ō	MD Dorchester	Cambridge			10d. Inside City Limits 1 ☐ Yes 2 X No
the 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What	Country?
h with		210 Linthicum Drive	21613		nited S	
deat	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No-		merican Indian,
36 after	by Fu	1 Never Married 2 Married 1 XYes 2 No	1 ☐ Yes 2 ▼ No Specify:	110011, 0(0.)	Black, W Specify:	
1215-0036 within 72 hours after and then and then then then then then then then then	ed b		edent's Usual Occupation			
in 72	plet	(Specify only highest grade completed) (Giv.	s kind of work done during most of workir DO NOT use retired)	20	6b. Kind of Busine: Commeri	•
d with	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Eng :	ineer/Owner		efridge:	
ING 21215-0036 be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or items 23a or 28a-1 show event, the Medical Examinst must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
	0	Robert Thomas Knox		_	h Mulli	
25 PE 20 00		The state of the s	ing Address (Street and Number or Rura			
_ 550.		20a. Method of Disposition 20b. Place of Disp	S Riverside Dr.		etary, 1 Oc. Location - City	
0 9 0 = 2		1 Property 2 Comption 3 Demonstrate Comptery, cre	Hill Cem. 07/11		·	Maryland
Haltimy p-mit. Pag Department In portent; any injury of		_ ',' //		-		
		Comme III. Come	2. Name and Address of Facility Fra 216 N. Main St.,	reder	arspurg	Home, P.A. , MD 21632
		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	r respiratory arres	st,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Heart tailu	re		3 diys
Examiner		Due to (or as a consequence of):	Board Fortuna			1
	je.	Sequentially list conditions, if any, leading to immediate b. Use to (u. as a consequence of):	may fall org			1 TEGT
cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events				
/6U, te be executed ysician and e burial-transit		resulting in death) Last Due to (or as a consequence of):				
. BOX 68 / 60, death certificate be executed e attending physician and id for use as the buriat-transit	dicai	d				
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BOX eath cert attendin for use	clan	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of d Month	delivery Day Year
the day the ached	ysi	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown				
Ords, P.O requires that the seen signed by th hould be detache	by Physicl	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	icco use contribute	to the cause of death?
Cords w require been sig		Vig yetes Mellitus		1 ☐ Yes	3□ 1000 3□	Probably 4 Unknown
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The The	Con	. 17		perform	ed? death	es 2 No
Vital Ilcien: 1 certifical rector, p	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one		
this ald	<u>1</u>	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ EP/Outpatie 27 Manner of leath 28a. ate of Injury 28b. Time			ce 6 Other (Sp	pecify)
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DIVISION I or Attending after death. I Director; After	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s		8f. Location (Stre	et and Number or	Rural Route Number.
s after	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
DIVI To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	nd due to the cau	ise(s) and manner	as stated.
the H hin 24 the F nplete	Aedi	and manner stated.				
To To	Σ	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Mg	nth, Day, Year)
		U. Ker	1771193		7/1/0	5
		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) B. Co. St.	+ C.	n harden	MO 211.17
St	ate	31. Date filed (Month, Day, Year) 3. Registrar's Signature	1 / M. 1	Cal	11 11 1che	(1) (1)
Regis		JUL 0 8 2005				

			State of Ma	aryland / Depa					
		yr.	Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of L	Jeath	2. Date of Dea	Reg. No.	3. Time of Death
Į.	Physici						Month	Day Y	ear
	/Medic Examin		Michael William Lo	ng	4b. City, Town, or	Location of Death	June 28	3, 2005 4c. County of	10:20 A M
	Lydillii	iÇi	7201 Kidmore Lane		Lanham			Prince (Georges
	. Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h g	Birthplace (State or Foreign Country)
	Director		579-42-0677 1\(\frac{1}{3}\)M 2□ F	71 Yrs.			July 10		New Hampshire
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary I sh	tor	Maryland Prince Georges	Lanham					1 ☐ Yes 21 No
	or 28s	Directo	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	at Country?
	23£ c		7201 Kidmore Lane		20706			United	States
	er dea	Funeral	11. Marital Status 12. Was Decedent I Amed Forces?	Ever in U.S. 13. 13. 1	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	American Indian, White, etc.
36	rs afte	by F	1 Never Married 2 Married 1 Types 2 Notes, Give 1 Yes, Give 1 Yes, Give 1 Year or Dates:	1954	1 ☐ Yes 2 🗓 No	Specify:		Specify: V	Mhite
9	72 hours after death with the Maryland naturel; or items 23c or 28a-f show disal Examiner must be notified at		15. Decedent's Education		dent's Usual Occupa			16b. Kind of Busin	ess/Industry
215	b. "Bo "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	life.	kind of work done d DO NOT use retired)	furing most of work.)	ing		
2	filed within Hygiene. other than "	Соп	12	Sales				Long Fen	ce
and	be fit ntal H ad ott	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	_	· ·	
Ĕ	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked to the than "naturel", or items 23s. or 28a-1 show to marked to the than "naturel", or items 23s. or 28a-1 show the marked to the modified at	은	Harold Long 19a. Informant's Name/Relationship (Type, Print)	19h Mailir	ng Address (Street a	Mary	La		ite Zin Code)
Baltimore, Maryland 21215-0036	is 1 and 2 should of Health and Mer item 27 Is marke other treumatic		Michael F. Long, Son		Ansley Clo			•	ite, zip codej
ē,	s 1 ar		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		Date	20c. Location - Cit	y or Town, State
Ë	Pages nent of ont: If its		1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 1 ☑ Donation 5 ☐ Other (Specify)	Fairfax Me	emorial Pa	July 2005		Fairfax,	Vircinia
a	permit. Pages Department of importent: If it any injury or o		21. Signature of Funeral Service Licensee		Name and Addres				VIIBINIA
<u> </u>	88308		M0095	0 99	02 Braddo	ck Rd.,F	airfax,	VA 22032	
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	uted	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events						
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8760	requires that the death certificate be executed teen signed by the attending physician and hould be detached for use as the burial-transit	dical	d						
9	eath certifica attending ph for use as t	/Mec	IF FEMALE: 22c If yes, outcome	of programmy					
Вох	eath c attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Very 2 National 23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year
o.	the de y the	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	unio or death 30					
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rds	w require been sig should b						1 □ Y	es 2 No 3	Probably 4 X Unknown
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	The ate h page	Com					perfor	med? dea	th? Yes 2 No
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	ei or Att s after d ii Direct id in by	Sert	4 Homicide determined building, etc	c. (Specity)			City or Tow	n, State)	
	To the Hospitei or Attending within 24 hours after death. To the Funerei Director: Attercompletely filled in by the fune		29a. Certifier 1 Certifying Physician: To the best of Check only 2 Medical Examiner: On the basis of	of my knowledge, death	occurred at the time	e, date and place,	and due to the c	ause(s) and manne	er as stated.
	the H nin 24 the 5 nplete	Aedical	one) and manner sta	ted.					
	T with	Σ	29b. Signature and title of certifier	H 3.	29c. License			29d. Date signed (A	
19	371		30. Name and address of person who completed cause of di	nath (Itam 22a) m	Doing)	>5572	·/ J	June 29,	2005
•				Hospital	Drive	Chave	La M	Tune 29,	i i
	Sta	te		ar's Signature	Carle B		7	7	
	Registr		JUL 0 1 2005	in to Pape	A COLUMN TO THE PARTY OF THE PA				

				State of Man	•	artment of F			ene 9. NQ () () !"	20100
		Physici	an	1. Decedent's Name (First, Middle, Last) David Arthur Lanham		imouto or	Dodin	2. Date of Death Month	Day	Year	3. Time of Death
		/Medio Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death	June 27,	2005 4c. County	of Death	11:35p ^M
		Zami		Suburban Hospital		Bet	thesda		M	lontgo	mery
		Funeral		1 DM 2 DE	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		ace (State or Foreign
		Director		338.20.2425 XX 77	Yrs.			Sept.1,	1927		nois
		show			Dc. City, Town or Loc	cation			-	10	d. Inside City Limits
		e Mar	ctor	MD Montgomery	Bethesda	a					1 ☐ Yes 2X No
		deeth with the Maryland ms 23s or 28s-f show rives be notified at	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of V	What Count	ry?
		s 23a		6219 Goodview Street	1.110		20817		U.S.A		
		ter de Inver	Funerai	11. Marital Status 1 □ Never Married 2 【 Married 12. Was Decedent Eve Armed Forces? 1 □ Never Married 2 【 Married 12. Was Decedent Eve Armed Forces?	If	was Decedent of F f Yes, specify Cuba	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		e - America ck, White, e	
	036	al', or	Þ	1 ☐ Never Married 2 🕅 Married If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	I□Yes 2\XXNo	Specify:		Specify	<i>/</i> :	White
	5-0	72 hours after deeth w "natural", or Items 23a	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup	oation during most of work d)	sing 1	6b. Kind of Bu	usiness/Indi	ustry
	121	within ane. than	Completed	Elementary/Secondary (0-12) Cotton (1-4or 5+)	Physi		d)		Med	lical	
	d 2	be filed within 72 hours after death with the Maryla hal Hygiene. od other than "natural", or Items 23s or 28s-1 show event, the Madical Examiner must be notified at		17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Mi	aiden Sumaп	7e)	
_	Maryland 21215-0036	2 should be filed within 72 hours after and Mental Hygiene. is marked other than "naturat", or Ite aumatic event, I're Mudical Examination.	To Be	James Howard Lanham			Ma	aude G. N	ation		
کے		permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Type, Print) Jean Lanham/ Wife		-	Street]			State, Zip (.0817	Code)
9	Baltimore,	es 1 and 2 of Health I item 27			20b. Place of Dispos	sition (Name of natory or other place	ce)	Date 20	Oc. Location -	City or Tow	vn, State
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				23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arres	it,		Approximate Interval Between
		Pnysician	Ø.		MIChun	VMY A	1131				Onset and Death
		/Medical Examiner		Due to (or as a co		10 0	2 . 20 .				
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5		outed id ansit	Examiner	ray, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
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4	8760	cate b	hysician/Medicai	d							
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૭	Вох	atten atten	cian	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Dat Mor	e of deliver	y Day Year
	0	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 4 ☐ Fregnant at time 9 ☐ Unknown 9 ☐ Unknown							
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9	ord	v require been sig should b		VONTRATUR OUPNONT 1	W WALL	MAJU	une	1 🗆 Yes	2 🗆 No	3 Proba	bly 4 Dbnknown
7	Records,	has be	ompieted					24a. Was an autopsy	24b. V	Vere autops prior to com	sy findings available pletion of cause of
હ		yslcian: The is certificate hidirector, page	Con					performe 1 Tes 2	9d7/ c	ieath? Yes 2	
_	Vital	slcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		2□ DOA Oth	000	h (Check only one)			
\prec	of	Physic ruthis aral di	: To	1 Yes 2 No 105shiai. 1 patient 27. Mann of Death 28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of	28c. Injun	4 LI Nursing Ho	me 5 Residen			
10	ion	nding Ph ath. r: After th e funeral	ation:	1 atural 5 Pending (Month, Day Ye 2 Accident investigation	ear) Injury		k? Yes 2 □ No				
drid	Division	r Attener deat	Certifica	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (5	At home, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		er or Rural	Route Number,
Ø		iltal o irs aft ral Di									
1-1		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner and manner stated	amination and/or invi	occurred at the tin estigation, in my o	me, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and ma a and place, a	nner as star and due to t	ted. he cause(s)
1		To th withir To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number	290	d. Date signed	(Month, D	ay, Year)
		12		h/1100 W	2.	52	1774		6/27	105	•
		(20))	30. Name and address of person who completed cause of death			IN a MA A	774 00 .	0 0		
		Sta	te	LEV (WTO W M) 860 31. Date filed (Month, Day, Year) 32 Registrar's	Signature	TORU 100	בי ויייטו דיי	11150M M	0 70	814	
		Registr		31. Date filed (Month, Day, Year) JUL 0 1 2005 32 Aegistrar's	Signature	Ne					

			For State Registrar	State of Ma	ryland / Depa	artment rtificate			d Mental H	ygiene Reg. No		221.00
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	Examir Funeral Director		4a. Facility Name (If not institution, give Washington Count: 5. Social Security Number 6. S 212–10–0050	v Hospital	(In yrs. last birthday) 88 Yrs.	If Under 1	Hage	erstow If Under 24 I Hours	n Hrs. 8. Date of B	irth Day, Year)	9. Birt	n County hplace (State or Foreign unity) gland
	σ		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo				- Joure		/ <u> </u>	10d. Inside City Limits
	th the Mar or 28a-f si e notified	irector	Maryland Washine 10e. Street and Number	gton	Willi	amspor				10g. Cit	izen of What Co	1 Yes 2X No untry?
336	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I'm Medical Examinat must be notified at	by Funeral Director	16505 Virginia A 11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	Ve. C153 12. Was Decedent E Armed Forces? 1 □ Yes 2X N If Yes, Give Year or Dates:	0	Was Decede If Yes, specif			? (Specify Yes or Nuerto Rican, etc.)	1	ited Sta 14. Race - Ame Black, White Specify: Wh	rican Indian, e, etc.
1215-0036	within 72 horene. ene. than "natura he Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5-	(Give	dent's Usual kind of work DO NOT use HOMEN	done dur retired)	ring most of	working		ind of Business	Industry Residence
Maryland 21	ould be filed withi Mental Hygiene. arked other than atic event, Ina M	To Be Co	12 17. Father's Name (First, Middle, Last) Thomas H. Boyd			nomen		8. Mother's	Name (First, Middi lizabeth	le, Maiden	Sumame)	
- 10	1 and 2 should Health and Men em 27 is marke other traumatic		19a. Informant's Name/Relationship (Jean D. LeMasuri 20a. Method of Disposition			0 S. 2	9th		PRURAI ROUTE NUM Pt. C2 Ar	ling		ginia 22206
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	Physician /Medical		shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Con a s	θ.	Hear						Interval Between Onset and Death
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P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yoo 9 Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	⊒Ectopic pre					23d. Date of del Month	ivery Day Year
	n requires that the death been signed by the atte should be detached for		Part II. Other significant conditions of	ontributing to death bu	it not resulting in the u	nderlying ca	ıse given	in Part I.		,		the cause of death?
I Records,	The ate h page	Completed by							24a. Wa aut per 1 □ Yes	opsy formed?	prior to death?	topsy lindings available completion of cause of
of Vital	g Physician: The laver this certificate has eral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes		6 Other (Spec	eify)						
Division	To the Hospital or Attending Fwithin 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	Natural 5 Pending investigation 3 Suicide 6 Could not b determined	9 200 Place of Injur	ıry - At home, farm, st	М		s 2□No	281. Location City or To	(Street an own, State	d Number or Ru)	ıral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) (Check only one)	ysician: To the best on niner: On the basis of and manner sta	examination and/or in	h occurred a vestigation, i	t the time, n my opin	, date and pi	lace, and due to the occurred at the time	e cause(s) e, date and	and manner as I place, and due	stated. to the cause(s)
)	To th within To th compl	Me	29b. Signature and title of certifier Cumthia K	ather 5	ando no		License n	45 I		-	te signed (Monti	
SH	-Ÿ Sta	ate-	30. Name and address of person who Cynthia Kutto 31. Date filed (Month, Day, Year) JUL 06	completed cause of de	eath (Item 23a) (Type, CIS, MD 14 It's Signature				Church f	Road	Hage	rstown,
	Regist		JUL 06	2005 Jane	m H. 14	peter						

DHMH 17 Rev 1/2001

Elizabeth Boyd Le Masurier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7:10A M 2005 June 5 Clement Lewis 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Oxon Hill 607 Audrey Lane #201 8. Date of Birth Aug. 21, Year 1952 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Virginia 1₩ M 2□ F 225-78-2575 52 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Oxon Hill MD Prince Georges 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 607 Audrey Lane #201 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: 1971–73 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2√2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Appliance Co. Delivery 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Regina B. Vandiver Joseph Lewis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Audrey Lane #201, Oxon Hill, MD 20745 Laurie A. Lewis (wife) Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 6-30-05 Cheltenham, MD Cheltenham Vet. Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bell Funeral Home, P.A. 6503 Old Branch Ave., Temple Hills, MD 20748 23a. lant/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hyperkalemia Due to (or as a consequence of): Kidney Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) H ertension Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2**X** No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home STResidence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending 1 Natural 2 Accident M 1 TYes 2 No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier Zion D25725 6/28/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Nemati, M.D. 3611 Branch Ave., #407 Temple Hills, MD 20748

To the Hospitel or Attending Physician:

State Registrar

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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Pages 1 and 2 should be filed withIn 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

item 27 is marked other than "naturel", or items 23s or 28s-1 show other treumstic event, the Nedical Examinar minst be notified at

of Health and Mental Hygiene. If item 27 is marked other than

permit. Page Department of Importent: If any injury or once.

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Certification:

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The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) JUN 3 0 2005



DHMH 17 Rev 1/2001

			1 - For State Registrar 6-30-05 Amen	State of Ma	-	Departme			and M	_	giene	005	221.11
	Physici	an	Hegistrar 6—30—05 Ale. 1. Decedent's Name (First, Middle, Inc.) Chin Long I	Last)	<u> </u>	001111101	210 07 1	Journ		2. Date of De. June 2	ath	5 Year	3. Time of Death 11:00 a _M
	/Medio Examir		4a. Facility Name (If not institution, G Shady Grove Adve	ive street and number)			ty, Town, or ockvi				4c. Co	unty of Death	ry
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	Maryland a-f show	ctor	10a. State 10b. County MD Montgo	omery	10c. City, Tov	vn or Location							1 ☐ Yes 2\overline{\text{Z}\overline{\text{No}}\overline{\text{No}}
	ath with the 23a or 28	Funeral Director	10e. Street and Number 10827 Maple Cres				Zip Code 20854				Ma1	of What Coul	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any nivry or other traumatic event, the Modified Existification onto	by Fune	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 2 1 If Yes, Give Year or Dates:	Ever in U.S.	1	cedent of H pecify Cuba 2 No	ispanic Ori in, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: AS:	etc.
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	and 2 sho lealth and ! m 27 is me har traume	3	19a. Informant's Name/Relationship Vanessa Lim /Daug					and Numbe Cour		eat Fal			
Baltimore,	t. Pages 1 rtment of H rtant: If ite njury or oti		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	cemete	of Disposition (Pery, crematory of 1y Crem	r other plac	J	une	28, 20)5 A1	on - City or To	
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J	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only one)	Physician: To the best aminer: On the basis of and manner sta	examination at	e, death occurr nd/or investigat	ed at the tin on, in my op	ne, date and pinion, deat	d place, a	and due to the dead at the time, d	cause(s) and date and pla	I manner as si ce, and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier ELi30b	eth . Be	· iii		29c. License		37			gned (Month,	Day, Year)
0	R(5))	30. Name and address of person who ELIZABETH.	BIRU	9901	(Type, Print)	icon	Q ce	nter	5 DR	ive	Rock	ville, L
	Sta Registr	ar	JUN 3 0 200		ar's Signature	food							

DHMH 17 Rev 1/2001

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	Examir		4a. Facility Name (If not instituti					,		Location	of Death			4c. County Kent	of Death		
			Chester River 5. Social Security Number	6. S		7. Age (In yrs.	last birthday)	Ches If Under		OWII If Under	24 Hrs.	8. Date of B			9. Birthp	place (State or For	reign
	Funeral Director		212-34-4310		□M 2 X F	8		Months	Days	Hours	Min.	8. Date of B (Month, I March	12,	1925	9. Birthp Cour MD	ntry)	
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	with the	Direc	10e. Street and Number 21108 East SI	harı	Stree	t		10f. Zip		661			10g. US	Citizen of V	Vhat Cou	ntry?	
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			30. Name and address of person	W,	415	use of death (Ite	m 23a) (Type.	Print) Aue	-, C	reste	low	n, n	10	216	20		
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dical	David 4a. Facility Name (If not institution, give	Johnson	<u> </u>	Lord	r Location of Deat	10/	4c. County of	
iner	SACred HOAR	+ NASOITO	7/	Cumt	PPLANIC	-/	Alle	
al	5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9	. Birthplace (State or Forei
r	181-30-2051-A	X M 2□F 66	Yrs.			05/29/19		Pennsylvania
	Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Limit
ţō	WV Minera	1		Ridgeley				1 XYes 2 □ N
Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	at Country?
	Route 1 Box 47				26753		USA	
Funerai	11. Marital Status	12. Was Decedent Ever i Armed Forces?		Was Decedent of H If Yes, specify Cub-	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
ted	15. Decedent's Ed	ucation		dent's Usual Occup		dring	16b. Kind of Busin	
Completed	(Specify only highest grad	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of wol	rking		
	12	4	E1	ngineer	40. 14-4		Tire and	Rubber
Be	17. Father's Name (First, Middle, Last)	Diahamd	Lore	a	Eleanor	ne (First, Middle, i	Arlene	Johnson
Į.	Allan 19a. Informant's Name/Relationship (7	Richard		ng Address (Street		ıral Route Number		
	Pauletta C. Lord / wi			te 1 Box 47			-	
	20a. Method of Disposition	20	b. Place of Dispo				20c. Location - Cit	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation	1	•	Crematory	07/14	/2005	Cumberland	, Maryland
j dike	21. Signature of Funeral Service Con-	See C	22	2. Name and Addre	ss of Facility A	dams Family	Funeral H	Home, P.A.
ä	1 Kohut C	Ullen		404 Deca	tur Street	, Cumberlan	id, Harylai	id 21502
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	CED	_	SEM A	correspiratory arm	est,	Approximate Interval Between Onset and Death
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the sequence of the se	b. Due to (or as a con						
dicai		d						-
Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ f 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date o Month	f delivery Day Year
H -		ontributing to death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did tot		te to the cause of death?
by	Part II. Other significant conditions co					1 □ Ye	es 2 □ No 3[Probably 4 Unknow
Completed by	Part II. Other significant conditions co					24a. Was a autops perform	n 24b. Wer y prio ned? dea	re autopsy findings availab r to completion of cause of
Be Completed by	25. Was case referred to medical examiner?	Hospital:		Oth	ar	24a. Was a autops perform 1 Yes 2	n 24b. Wer y prio ned? dea 2 2 No 1 —	re autopsy findings available to completion of cause of th? Yes 2 No
To Be Completed by	25. Was case referred to medical		2 □ ER/Outpatier 28b. Time o	f 28c. Injur	er: 4 Nursing H	24a. Was a autops perform 1 Yes 2 ath (Check only onlone 5 Reside	n 24b. Wer y prio ned? dea 2 2 No 1 —	re autopsy findings availab r to completion of cause of th? Yes 2 🗷 No
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Jamie R. Miller 05-4712 AKG

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12	1	= For Unpend Item Registrer	23a,27,28	Marylan a-f p	d/Depa er me (<i>Cer</i>	rtment of H 846 8 4 tificate of l	ealth and 05 tas Death	Mental Hygier	ne N2 0 0 5	23614
Physician	ı	 Decedent's Name (First, Middle, Jamie Robin MI 	,				-	July 12,	оаж 2005 ^{Year}	3. Time of Death 5:45 PM м
/Medical Examiner	4	4a. Facility Name (If not institution, 17335 W. Washing	-			4b. City, Town, or Hagerst		h	4c. County of Dea Washing	
Funeral Director					last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Bir 1962 M	thplace (State or Foreign ountry) aryland
Maryland 1 show		Usual Residence of Decedent 10a. State 10b. County Pennsylvania	Franklin		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
atter death with the Maryland or items 23a or 28a-f show culter trust be rectified.		10e. Street and Number 5140 Bino Road				10f. Zip Code 172	25	10g.	Citizen of What C	ountry?
or its		11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒ Divorced	12. Was Deceder Armed Forces d 1 Yes 2 1 If Yes, Give Year or Dates	s? ⊈No	11	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
permit. Pages 1 and 2 should be filed within 72 hours after pages 1 and 2 should be filed within 72 hours after Important: if flem 27 is marked other than "natural", or its eny injury or other traumatic event, the Macient Examina once. To Be Completed by Fu	-	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4o	r 5+)	(Give	ent's Usual Occupa kind of work done of OO NOT use retired metal me	during most of wo.)	rking	Kind of Business	•
Mental Hys Mental Hys arked otha atic event,		17. Father's Name (First, Middle, L. Joseph R. Mille			-			me (First, Middle, Maid ilyn L. So	•	
and 2 should I salth and Men n 27 is marke isr traumatic		19a. Informant's Name/Relationshi Marilyn Miller			17335	W. Wash		t., Hagers		
Pages 1. ment of He ant: if iten ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		е _ с	emetery, cren -	sition (Name of natory or other place on Mem. P			Location - City or gerstown	Town, State , Maryland
permit. Departr Importr eny inj		21. Signature of Funeral Service Li	cense ////	asi	()	Name and Addres		INNICH FUN d., Hagers		E ryland 21740
Physician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on each	line. Land	Oxycod	one Into		c or respiratory arrest,		Approximate Interval Between Onset and Death
examiner ial-transit Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events	b. Oue to (or a	is a sonsaç	uanes of).					
icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or a	is a consequ	uence of):					
Attending Physician: The law requires that the death certific robath. •ctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as iffication; To Be Completed by Physician/Mec		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
quires that in signed b uld be deta		Part II. Other significant condition	s contributing to death	but not resi	ulting in the ur	derlying cause give	en in Part I.	23e. Did tobaco		o the cause of death? robably 4 Dunknown
D 25 a	-							24a. Was an autopsy performed	death?	utopsy findings available completion of cause of
Physician: The string of this certificate eral director, pagent of the string of the s		25. Was case referred to medical examiner? 1 ∰ Yes 2 □ No 27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of In		ER/Outpatient	3 □ DOA Othe	er: 4 ☐ Nursing H	ath (Check only one) Home 5 Residence 28d. Describe how in		_{cify)} at scene unk
P Sign		1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide	ot be led Place of led building,	njury - At ho atc. (Specif)	me, larm, stre	P ^M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 No	28I. Location (Street City or Town, St	and Number of R	ural Revie Number. N. Washington
To the Hospital within 24 hours e To the Funeral if completely filled Medical Ce		29a. Certifier 1 ☐ Certifying (Check only one) 1 Medical E	House Physician: To the besixaminer: On the basis and manner:	st of my kno of examina	wledge, death tion and/or inv	occurred at the time estigation, in my op	ne, date and place	St., Hagers a, and due to the cause urred at the time, date a	(s) and manner a	s stated. to the cause(s)
To the within To the compl		29b. Signature and title of certified	- PE	00.	el no	29c. License OCM	number E	29d. (July 13,	th, Day, Year) 2005
State		30 Name and address of person was all the state of the st	no completed cause of	death (Item	(23a) (Type, I ture	111 Pe	enn Stree	et Baltimo	re, Mary	land 21201
Registrar		JUL 18			4. fo	will				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	f Marylan		artment of rtificate o			-	giene Reg. v2. (0.0.5	234	15
ı	Physici	an	1. Decedent's Name (First, Middle	e, Last)				•		2. Date of De Month	Day	Year	3. Time of	
	/Medic	al	Ruth Moss 4a. Facility Name (If not institution	a pive street and nu	mber)		4b. City. Towr	n, or Location of	of Death	June		2005 punty of Death	2:25	A ^M
	Examin	er	15310 Beaverbro					Sprin				tgomery	7	
	Funeral Director		5. Social Security Number 051–18–2622	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Ye Months Day	ar If Under	24 Hrs. Min.	8. Date of Bir (Month, Da 07/13/	th ly, Year) 1922	9. Birthp Cour Germ	* -	or Foreign
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	ocation					1	0d. Inside Ci	ity Limits
	Maryli f aho	tor	MD Montgo	merv		lver Sp							1 X Yes	2 No
	h the	Director	10e. Street and Number	Jucty	543	LVCI D	10f. Zip Cod	0			10g. Citize	n of What Cour	itry?	
	eth wi	raic	15310 Beaverbro				20906					d State		
	er de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed Fo		.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Ori uban, Mexican	gin? (Spe n, Puert <i>o</i> f	cify Yes or No Rican, etc.)	- 14	Black, White,		
212-0036	ba filed within 72 hours after deeth with the Maryland ital Hygiene. id other than "natural", or Itams 23a or 28a-f ahow event, the Medical Examinar must be neillied at	þ	3 Widowed 4 Divorced	If Yes, Gi Year or D	ve		1⊡Yes 2⊠X1	No Specify:			S	pecify: Whit	:e	
<u>.</u>	"natur	Completed	15. Deceden (Specify only highes	t's Education st grade completed)		(Give	dent's Usual Oci kind of work do DO NOT use ret	ne durina mos	t of workir	ng	16b. Kind	of Business/Inc	dustry	
_	I within 72 iene, r than "na ine Medic	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		oational	,	pist		Soci	al Work	ξ	
<u> </u>	2 should ba filed v n and Mental Hygie I is markad other t reumatic event, ID	BeC	17. Father's Name (First, Middle,	Last)					-	(First, Middle	, Maiden Su	ımame)		
<u>ya</u>	outd b Ment Parkac	70	Louis Rosensto							fheime				
Maryland	d 2 sh th and th srr 17 Is rr treurr		19a. Informant's Name/Relations Leslie Friedhe		nter		ng Address <i>(Stre</i> Keepsak						Code)	
ē,	s 1 an if Heel item 2		20a. Method of Disposition		20b. F		sition (Name of matory or other p			ate		tion - City or To	wn, State	
Ē	Page nent o ant: If ury or		1 Burial 2 □ Cremation 1 Other (S		State	Lebar			6/30,	/2005	Ade1	phi, MI)	
saitimore,	permit. Pages 1 and 2 should be Depertment of Heelth and Menta Important: If item 27 Is marked any injury or other treumatic evone.		21. Signature of Funeral Service	Licensee	,	H	Name and Addines—Rir	naldi F	unera	al Home	, Inc			
	4D 2 6 0		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	ceused the deat		1800 New	/ Hamps	hire	Ave Si	lver	Spring,	Approximate Interval Bette Onset and I	te tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	d	diopulm		Arrest							
	Examiner				(or as a conseq g Cance:									
l.	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0	(or as a conseq									
_	be executad ician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq	uence of):								
00/	ate be executad hysician and the burial-transit	icai E		d										
ĝ	death certificate e attending phys id for use as the	ba	IF FEMALE:	T										
POX	leath certifica attending phi ifor use as th	ian/i	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live t	tcome of pregna birth 2 ☐ Feta nant at time of d	Ideath 3□	Ectopic pregna Other (specify)				230	 Date of delive Month 	,	Year
j.	that the de ed by the detached	Physician/M	1 □ Yes 2X No 9 □ Unknown	9□ Unkn		oam J	J Citiel (specify)							
as, r	S E 9	by	Part II. Other significant condition	ons contributing to d	eath but not res	ulting in the u	nderlying cause	given in Part I.	٠	1	obacco use Yes 2□t	contribute to th	ne cause of d ably 4 □U	
Ö	req baer shou	iete								24a. Was		24b. Were auto		
Ě	9 2	Completed								autop perfo 1 ☐ Yes	rmed?	death?	npletion of ca 2 □ No	ause of
Vital	siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				1,		of Death	(Check only o	ne)			
5	Phys this ral di	1. To	1 Yes 2 XNo 27. Manner of Death		Inpatient 2 of Injury th, Day Year)	ER/Outpatier 28b. Time of	IL SLI DOA	Other: 4 Nu njury at Vork?		ne 5 🕅 Resident		Other (Specify	')	
VISION	Attending P ir death. ector: After by the funera	ation;	1 X Natural 5 ☐ Pendin 2 ☐ Accident investig	9	th, Day Year)	Injury		Vork? ∐Yes 2∐I	No					
_	2 9 2 6	Certificati	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	1286. Place	of Injury - At ho ing, etc. (Specif	ome, farm, str	eet, factory, office	се	2	8f. Location (3 City or Tox		lumber or Rura	Route Num	iber,
	To the Hospitel or At within 24 hours effer of To the Funerel Direct completely filled in by	edical (g Physician: To the Examiner: On the b and man										;)
	To th within To th comp	Me	29b. Signature and title of certifie	ns/_				ense number				igned (Month, I	Day, Year)	
	5		, Acc	Y.oc	100			L245			06/29	/2005		
			30. Name and address of person					. 77.	.d	M	2000	ı E		
	Sta	te	Dr. Jack Epste: 31. Date filed (Month, Day, Year)	10. MD 10	otu Coni legistrar's Signa	ture	ut Avent	ie kens	rngr	on, MD	2089			
L	Registr	_	JUL UI	2005	tegistrar's Signa	F GOL	West of the second							

DHMH 17 Rev 1/2001

or Attending Phyaician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

filled in by the funeral After death. after death. within 24 hours a To the Funeral D

> State Registrar

Medicai

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

000

3 Suicide

29a. Certifier

Julie

4 | Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Suall

DHMH 17 Rev 1/2001

Welfe

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

North

32 Registrar's Signature

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Street

KES-000

Baltimore

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28,2005

Maryland

		For	State of N	/arylan				Mental Hy	giene	
		1 - State Registrar	tte t and		Cer	tificate of	Death	2. Date of Dea	Reg. N2. 0 0	5 23417
Physici	an	1. Decedent's Name (First, Midd	A A	Me	\wedge			Month		(eer C) IO PM
/Medio Examin		4a. Facility Name (If not institution	on, give street and number	or)		4b. City, Town, o	r Location of De	ath	4c. County of	Death
		Coastal	11000	the	Lake	- Ja	lisbu	ry		Lomico
Funeral		5. Social Security Number	6. Sex 7	Age (In yrs. I	ast birthday) Yrs.	Months Days	If Under 24 H Hours Mi		h v, Year)	Birthplace (State or Foreign Country)
Director		220-32-1665 Usual Residence of Decedent		71_			11	5/4/19	34	MD
rylanc how	_	10a. State 10b. County	у	10c. City	, Town or Lo	cation				10d. Inside City Limits
Be-f s	ecto		cester		cean	·			10-01	1 ☐ Yes 2 🗷 No
with the a or 2	Funeral Director	10e. Street and Number	ft land			10f. Zip Code	21811		10g. Citizen of Wh	
ms 23	era	12 Candy Tu	12. Was Decede	nt Ever in U.	S. 13. V	Vas Decedent of H		(Specify Yes or No- erto Rican, etc.)		American Indian,
ILE IN 190000 filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23s or 28e-f show ant, the Medical Examiner must be malified at		1 Never Married 2 Mar	If Yes, Give	X No		r Yes, speciny Cuba I⊡ Yes 2 ∑X No		eno nican, etc.)	Specify:	White, etc.
hours fural;	d by	3 Widowed 4 Divorce	Year or Date	s:		lent's Usual Occup			16b. Kind of Busi	
in 72 in 72 in 74	olete	(Specify only highe	ent's Education est grade completed)	.5.)	(Give	kind of work done OO NOT use retired	during most of w	rorking	160. Kind of Busi	ness/moustry
d with giene.	Completed	Elementary/Secondary (0-12)	College (1-4d)r 5+)	Tele	phone 0	perator		Phone	Company
yidiliu ZIZ buld be filed with Mental Hygiene. arked other than atic event, IIN M	Bec	17. Father's Name (First, Middle	, Last)					ame (First, Middle,		
should be nd Mental marked c	ို	Bampton Jone			10h Mailie	- Address /Ctrast		n Croppei Rural Route Numbe		tato Zin Codo)
Mal d 2 sho th and th and treum		19a. Informant's Name/Relation Carmen Paul		d				, Ocean I		
patimical ey, interpretable to the control of the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event. The Maryled Examiner made to building at once.		20a. Method of Disposition		20b. P		sition (Name of natory or other place		Date		ity or Town, State
mit. Pages partment of I portent: if ite		1 Surial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (3		(e		lemorial	1	/6/2005	Berlin,	MD
Dallillo permit. Page Department o Importent: if any injury or once.		21. Signature of Fundal Service	e Licensee		22	. Name and Addre	ess of Facility T	he Burba	ge Fune	ral Home
0 89E29		11 till	/Justale		-			, Berlin,		
		23a. Part1. En et al disease, di shock, or hi an failure. Lis Immediate Cause (Final	or complications that sus st only one cause on each	1 line				ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a	as a consequ		ON,A	יד			
Examiner			1 . 0		-IA	CA	NEF	7		
P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D. Elue to (ur	a country	ence of):			1.		2
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VICIAN: The sician: The certificate rector, pag	Be (25. Was case referred to medical examiner?				0.4		eath (Check only or	ne)	
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o the o the omplei	Med	29b. Signature and title of certific	and manner	SIMING.		29c. Licens	se number		29d. Date signed (Month, Day, Year)
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5		30. Name and address of person		of death (Item	23a) (Type,	Print) Con	STAL	HOSPICE	EAT	AKTE
ET 3		YAMES W.	ISAACS	atrada Circ	hura	SAU	15BUI	ZY MA	ASY CAM	0)> 2/80/-
Sta Registi		31. Date filed (Month Day. Year	5 2005 32. Co	Strar's Signal	b A	roll				

DHMH 17 Rev 1/2001

			For State Registrar	State of M	laryland / Depa <i>Cei</i>	artment of F			ene • • • • • • • • • • • • • • • • • • •	23418
	Physici		1. Decedent's Name (First, Middle, Last Irene Elizabeth		ller			2. Date of Death Month	Day Year	3. Time of Death 7:06 AM
	/Medic Examin		4a. Facility Name (If not institution, give Washington Count	street and number)	Hage	r Location of Dea erstown		4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Se 216–22–1782 Usual Residence of Decedent	x 7. A	ge (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			rthplace (State or Foreign country) Maryland
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-f show any injury or other traumatic event, if a Modical Ever' is at Irrasi Le ricillical at ance.	led by Funeral Director	10a. State 10b. County Maryland Washingt 10e. Street and Number 19603 Shepherdsto 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	DWN Pike 12. Was Decedent Armed Forces 1 Yes 2 K If Yes, Give Year or Dates:	No 16a. Deced	Oro 10f. Zip Code 217 Nas Decedent of Uba 1 Yes, specify of the Code 1 Yes Wall Occup	ispanic Origin? (s an, Mexican, Puer Specify: ation	Specify Yes or No- to Rican, etc.)	g. Citizen of What C Jnited Sta 14. Race - Am Black, Wh Specify: V 6b. Kind of Busines:	ates encan Indian, ite, etc. vhite
ınd 21215	be filed within 7: ntal Hygiene. Id other than "n event, II v. Medi	To Be Completed	(Specify only highest grace Elementary/Secondary (0-12) 9 17. Father's Name (First, Middle, Last) John Luther Hetze	College (1-4or	5+) life. (kind of work done on NOT use retired	18. Mother's Na	_	aiden Sumame)	Manufacture
Baltimore, Maryland 2121	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 ia marka any injury or othar traumatic once.	70	19a. Informant's Name/Relationship (T) Wayne Miller (sor 20a. Method of Disposition 1	ope, Print) Removal from State	20b. Place of Dispo cemetery, crem Mt. View	25 Shephe sition (Name of natory or other place Cemetery Name and Addre	and Number or A rdstown ce) 7 7-6- ss of Facility Do	Pike Boon Date 2 -05 ouglas A.	sboro, Ma oc. Location - City o Sharpsbur Fiery Fur	ryland 21713
8760,	Physician /Medical Examiner physician and physician and the pright the pright that the pright the pright that the pright the pright the pright the pright that	licai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	line. CUTE MY, s a consequence of): TDEY FEN s a consequence of):		il Ing	c or respiratory arres	Y	Approximate Interval Between Onset and Death Hys
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I Reco	aician: The law re certificate has bee rector, page 2 sho	Completed						24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	utopsy findings available completion of cause of s 2 No
Division of Vital Records,	ding Phye T. After this funeral di	To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Hospital: 1 Inpati	ury 28b. Time of Injury	28c. Injun Wor M 1	er: 4 Nursing l	ath (Check only one, Home 5 Residen 28d. Describe how	ce 6 □Other (Spe	
Div	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification;	4 Homicide determined 29a. Certifier Certifying Phy	building, e	njury - At home, farm, streatc. (Specify) t of my knowledge, death	occurred at the tin		City or Town, e, and due to the cau	State) use(s) and manner a	s stated.
	To the Hospita within 24 hours To the Funeral completely filled		29b. Signature and title of certifier	and manner s	~	29c. Licens	e number	296	d Date signed (Mon	
OB F	Sta Registr	te	30. Name and address of person who come address of person who come address of		death (Item 23a), Type,	Bill lap	hans k	ed Boon	sboso 1	40 21713

			1 - For State Registrar	State of	Maryland / De	partment of H e <i>rtificate of L</i>		nd Mental I	Hygien ∤ Reg. N	1000	23419
			1. Decedent's Name (First, Middle	le, Last)				2. Date o		ay Year	3. Time of Death
ı	Physici /Medic		Nevin Elwood I	Mauck Sr.				June		2005	7:40 AM M
	Examin		4a. Facility Name (If not institution		ber)	4b. City, Town, or				c. County of De	
			13640 Village 5. Social Security Number		7. Age (In yrs. last birthde	Maugans				Washing	
	Funeral Director		220-30-7785	1 M 2 □ F	7/1 Yrs.	Months Days	Hours	Min. (Month	Birth , Day, Yea	1930 Ma	irthplace (State or Foreign Country)
	70		Usual Residence of Decedent		74			TNOV.		L900 Ma.	
	arylar show	_	10a. State 10b. County		10c. City, Town or						10d. Inside City Limits 1X Yes 2 □ No
	he Mi	ecto	MD Wash:	ington	Maugans	10f. Zip Code			10a C	itizen of What (
	with the sales	Funeral Director	13640 Village	Mill Dr		21767				SA	Southly :
	death	era	11. Marital Status	12. Was Deced	dent Ever in U.S.	3. Was Decedent of Hi	ispanic Origi	in? (Specify Yes o	r No-	14. Race - An	nerican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, if a Medical Error is at most be rediffed at once.	by Fur	1 ☐ Never Married 2 🖾 Mar 3 ☐ Widowed 4 ☐ Divorced	l If Yes, Give	2 □ No	If Yes, specify Cuba 1 ☐ Yes 2 ☐ No		Pueno Rican, etc.	,	Black, Wh	White
Ş	72 ho natur	Completed by	15. Deceden	nt's Education est grade completed)	16a. De	cedent's Usual Occupa	ation during most o	of working	16b.	Kind of Busines	s/Industry
2	vithin ne.	mpie	Elementary/Secondary (0-12)	College (1-4	4or 5+)	. DO NOT use retired	1)				
7	illed v Hygie ther t		12th 17. Father's Name (First, Middle,	Last)	Pipe	Fitter	18. Mother	's Name (First, Mid			ufacturing
and	d be dental l	To Be	George Washing					tie Reje			
Maryland	shou ind M ind M ind M	-	19a. Informant's Name/Relations		19b. Ma	iling Address (Street a	and Number	or Rural Route Nu	mber, City	or Town, State,	, Zip Code)
ž	and 2 valith a valith a valith a valith a valith a		Dolores J. Mai	uck / Wi	ife 1364	0 Village	Mill	Dr. Maug	ansvi	lle, MD	21767
ore	of He of He or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from Si	tate !	position (Name of rematory or other place		Date		_ocation - City o	
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Bal	permit Depar Impor any in		21. Signature of Funeral Service	Licensee	2	22. Name and Addres	omac S	Gerald N treet,Ha	. Min gerst	nich Fu own,MD	neral Home 21740
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			resulting in dealing								
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. N2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:15a_M July 2005 Joseph Machione /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Howard Ellicott City 2921 Woodwick Ct. If Under 1 Year | If Under 24 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours M 2 ☐ F Yrs. 11/24/1936 New York **Director** 68 087-30-0402 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ehow. rthan "naturel", or Items 23a or 28a-f ehov the Medical Examiner must be nutified at 1 Yes 2X No Ellicott City Md. Howard Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2921 Woodwick Ct. 21042 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. to the second s 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No SpecityWhite Ď 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government CPA 4yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nit. Pages 1 and 2 should be fiil autment of Health and Mental Hoortant: If item 27 is marked oth injury or other traumatic even Agnes Long Lawrence Machione 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Machione/wife 2921 Woodwick Ct. Ellicott City Md.21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Important: If eny injury o once. St.Mary of the Snow 7/8/2005 Saugerties, NY. 22. Name and Address of Facility Harry H. Witzke's Family F. H. Inc. 21. Signature of Funeral Service 4112 Old Columbia Pike Ellicott City, Md. 21043 △ MOO845 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -HOLANGIOCARCINOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 2 1 No 1 Yes 2 \ No 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Praesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After t 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 142680 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 21042 PHICE 9051 BALTIMORE NATIONAL SHEIKH MID MBA 31. Date filed (Month, Pay, Year) 32. Resistrar's Signature State Registrar Someth.

DHMH 17 Rev 1/2001

MEADIA E. MCCARTER

		1 - For State Registrar		Ce	rtificate of l	ealth and N Death		eg. N2 11	5 231.21
		1. Decedent's Name (First, Middle, La	tst)		40_3		2. Date of Deat Month		3. Time of Death
Physici /Medi		Meadia Wil		er			Duly	52	0616A
Examir	ner	4a. Facility Name (If not institution, giv	- 1 /	as DITA	4b. City, Town, or	Location of Death	NEF	4c. County of	
Funeral		5. Social Security Number 6. S	Sex 7. Age ((In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9	. Birthplace (State or Foreign
Director		214-07-7646	1□M 2 X F	93 Yrs.	Months Days	Hours Min.	July 10	, 1911	Maryland
land		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or Lo	ocation				10d. Inside City Limits
Mary C	tor	MD Dorche	ster		Cambri	dge			1 XYes 2 □ No
2 th 15 mg 12 mg 1	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	at Country?
ath w	rai	202 Aurora St.	10 Was Decedest Su		1	1613	acity Voc as No	USA	American Indian,
fter de ritem iner	Fune	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		White, etc.
rai', o	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	white
be filed within 72 hours after death with the Maryland tial hygiene. Id other than "natural", or items 23e or 28e-f show event, it a Medical Exeminer must be incitiled at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occupa kind of work done of DO NDT use retired	luring most of worl	king	16b. Kind of Busin	ness/industry
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al Hyg other	Be C	17. Father's Name (First, Middle, Last,)			18. Mother's Nam	ne (First, Middle, A		
y can ould b Menta warkad	70	Thomas Willey					a Shorte		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. The programs of Health and Mental Hygiene. The programs of Health and Mental Hygiene. The programs of Health and Mental Hygiene. The programs of the programs of the programs of the programs of the programs of the programs of the programs.		19a. Informant's Name/Relationship (1	ng Address (Street a				
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permit. Departm Imports any inju		21. Signature of Funeral Service Licer			2. Name and Addres		homas Fur		
3 88 5 5 8		Brien K. Bu			700 Locus				613
		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		,			est,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Arterios	clere v c	460 VF	Orsease			
Examiner			Due 10 (01 as a 0						
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Registrar
DHMH 17 Rev 1/2001

State

300 AURORA

STREET CAMBRIDGE

MD 21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THANNY

31. Date filed (Month, Day, Year) 32. Regis ar's Signature

NOMIAN

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Leonard Murphy 2005 3:45A Estelle June 30, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Dorchester 8. Date of Birth (Month, Day, Year) Cambridge Mallard Bay Care Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 200F Maryland Director 214-28-3446 Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes XXNo Director Cambridge Dorchester Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code US 21613 1 Kiowa Road "natural", or itama 23a Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puento Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XX o Specify. Specify þ XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. Education School Teacher 11 5+ if Health and Mental Hygi item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be Pages 1 and 2 should be Daisy Virginia Stevens Levi B. Leonard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 KiowaRoad Cambridge, Maryland 21613 Virginia Murphy Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot once. XX Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)
21. Signature ☐ neral Service ☐ ensee 7/5/05 Cambridge, Maryland Dorchester Mem Park 22. Name and Address of Facility
Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Congestive heart **Physician** 5 years disease or condition resulting in death) /Medical Due to (of as a consequence of): fibrillation Examiner atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed r heumatoid and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the burial-Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II, Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown has been signed 2 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page this certificate 2 D No 1 Yes 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director; 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide To the Hospital filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HOO5 99 73 30 Name and ddress of person who completed cause of death (Item 23a) (Type, Print) OUBramble Street Cambridge, MD 21613 2005²². Reg grar's Signature 31. Date filed (Month, Day, Y State Registrar

P.O. I

Division of Vital Records.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours aftar deeth.
To the Funeral Director: After this certificata has been signed by the attending physician end
completely filled in by the funerel director, page 2 should be datached for use as the bunal-trensit

_					Certificate o	f Death		giene Reg. No. O O	0 =	00100	
cian	1. Decedant's Nama (First, Mid Edna E	dde, Last) lizal	neth l	Murray			2. Data of Dea Month	Day	Year Year	32 Time of poem 3	
cal	4a Facility Nama (If not institut.					4b. City, Town, or	July Location of Death		005 of Death	1325	
er	101 Smith	_		,		Federal	sburg	Car	olin	ıe	
	5. Social Security Number 214-32-0499	6. Sax 1 □ M	7. A	ga (In yrs. last 72	Yrs. If Under 1 Yas Months Day			, Year) 1933		laca (State or Foreign try) yland	
tor	Usual Rasidance of Decedent 10a. Stata 10b. Coun MD Ca	rolin	ıe	10c. City, T	own or Location Federal	lsburg			10	0d. Insida City Limits	
Funeral Director	10e. Street and Number 101 Smith	Stree	e t.		10f. Zip Code	1632		10g. Citizen of V United		-	
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eted	15. Deceda (Specify only high	ant's Educat	tion completed)	1	6a. Dacedent's Usual Occ (Give kind of work dor life. DO NOT use reti	cupation ne during most of wo	rking	16b. Kind of Bu	usiness/Ind	lustry	
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0	James Macer					Cora	Neal				_
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	Michael					Main St	., Fede	ralsbu		MD 21632	
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ician		1. Decedent's Name (First, Middle, Last,)					2. Date of Death Month		O C	-3. Timerof Death
dical	L	Vida	May		<u>N</u>	lurray		July	8, 2005		3:10 P
niner	1	4e. Facility Name (If not institution, give 344 Mountain View Dr		oer)		4b. City, Town, or Cumber	Location of Death		4c. County of	legany	У
al		5. Social Security Number 6. Se		Age (In yrs.	last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,			ice (State or Forei
or		214-12-3390	M 2√2 F	94	Yrs.	Months Days	Hours Min.	02/14/19:	1		y Virginia
	\vdash	Usual Residence of Decedent 10a, State 10b, County		10c, Cit	y, Town or L	ocation				100	d. Inside City Limit
5	- 1	MD Allegan	V			erland					1 ☐ Yes 2 ☑ N
Director	-	10e. Street and Number	,			10f. Zip Code		10	g. Citizen of Wh	nat Countr	y?
		344 Mountai	in View D	rive		21	502		USA		
Funerai			12. Was Deced	ent Ever in U.	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No-	14. Race	America: White, et	
by Fu		1 Never Married 2 Married	1 Tes 2	₹No		1 ☐ Yes 2 ☑ No	Specify:	,	Specify:	***************************************	
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Completed		Elementary/Secondary (0-12) 5	College (1-4	or 5+)		Homemake	r		Home	maker	
Be C)	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, N	laiden Sumame))	
70 8)	Charles		Bernard	<u> </u>		Mary	Jar	ie	Wil.	son
		19a. Informant's Name/Relationship (Ty			19b. Mai	ing Address (Street a	and Number or Run	ral Route Number,	City or Town, St	tate, Zip C	Code)
	-	Jane E, Hanchett /dau	ıghter	20h P		Valley Mean of Valley Mean			Californi Oc. Location - C		
	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ F		ate c	semetery, cre	matory or other place	9)				
اند	-	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 		Sun		norial Park 22. Name and Addres	07/09/		Cumberla		
300		V 12 0	4. len	_1			ır Street,				
n al		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ne cause on exa a. End Sta	line.	eimer's	ter the mode of dying Dementia	g, such as cardiac	or respiratory arre	st,	J.	Approximate nterval Between Onset and Death
dicai Examiner		Sequentially list conditions, if any, leading to initialize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last). 	as a conseq							
Physician/Med		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown		h 2□Fete nt at time of d	I death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Month	,	y Year
by Pr		Part II. Other significant conditions cor	ntributing to dea	th but not res	ulting in the	underlying cause give	n in Part I.	23e. Did tob	acco use contrib	ute to the	cause of death?
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piet								24a. Was an autopsy		ere autops	y findings available
Completed								perform	ed? dea	ath? Yes 2	
Be (. [25. Was case referred to medical examiner?				Ta.		h (Check only one			
은		1 ☐ Yes 2 📉 No	lospital: 1 Inp		ER/Outpatie		4 Nursing Ho				
Certification;		27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of (Month,	Day Year)	28b. Time Injury	Work	at :? ∕es 2 □ No	28d. Describe hor			
Certifi		4 Homicide determined	28e. Place of building	f Injury - At ho , etc. (Specif	ome, farm, s y)	treet, factory, office	,	28f. Location (Str. City or Town,		or Hurai F	Houte Number,
edical				is of examina		th occurred at the tim nvestigation, in my op					
Σ		29b. Signature and title of certifier	0/		\cap	29c. License	number	29	d. Date signed (Month, Da	ay, Year)
		Mobustiano	1/1/2	waya.	1	D001	L4865		July 11,	2005	
		30. Name and address of person who co	on pleted cause	of death (Item		, Print)			-		
	-	Robustiano	T Roman	T M CT	500	Memorial Av	ronuc CL	orland M.	m-1 1 2	1500	

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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ľ	Physici /Medic	_		Robert			tis		Mille	er			2. Date of D Month Jul	eath y 1	0ay Year 1 -12- 20	3. Time of De 20:56	
	Examir Funeral		4a. Facility Name (I	ial_Hos		al	e (In yrs.	last birthday)	C1	y, Town, oi imber er 1 Year	land If Unde	r 24 Hrs.	8. Date of B	irth	Alleg	any	oreign
÷	Director		217-76-602 Usual Residence of	f Decedent		M 2 F	45	Yrs.	Month	s Days	Hours	Min.	(Month, D 09/21/		1	Sachusetts	
:	r 28e-f show	Director	WV		rgan		10c. Cir	y, Town or Lo Great	Caca					10 (10d. Inside City L	
	Vith u	급	10e. Street and Nu						101. 2	ip Code	_			10g. 0	Citizen of What C	ountry?	
	//2 hours affer death with the Maryland natural', or items 23a or 28e-f show Jigal Exert mr fritist be truffied at	by Funeral	11. Marital Status 1 Never Marr 3 Widowed		ried 1	ane 2. Was Decedent Armed Forces? 1 ∑Yes 2 ☐ If Yes, Give Year or Dates:		-		2542 cedent of Hoecify Cuba 2 No			ecify Yes or N Rican, etc.)	lo-	USA 14. Race - Am Black, Wh Specify:	ite, etc.	
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		To Be	Otis		Ju	nior		Miller			Ιτ	ngebor	ø		Go11e	ے	
	s 1 and 2 should by if Health and Menta Itsm 27 is marked other traumatic ex	-	19a. Informant's N	ame/Relation	ship (Typ	e, Print)			ng Addre	ss (Street		0	0	ber, City	or Town, State,		
	1 and 2 Health a tsm 27 ls		Debbie Mil	ler /	wife			36 K	ilgor	e Lane	, Grea	at Cac	apon, We	st V	irginia 2	25422	
	8°= 5		20a. Method of Dis 1 X Burial 2 4 Donation	Cremation		emoval from State	C	lace of Dispo emetery, cre et. Cem	matory o	r other plac)7/15/	Date 2005		Location - City o		
	permit. Pa Departmen Important: any Injury ance.		21. Signature of Fu	une al Service	License	θ /2		2							neral Home	,	
	40 = € 0		OZa Parti Fatori	luf	Or	Cele	المصادرة	Do not on						<u> </u>	aryland 2	Z1502 Approximate	
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_	certificate be executed ding physicien and use as the buriat-transit	dical Examiner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease or that initiated event: resulting in death)	S		Due to (or as											
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	i he law requires that the death ate hes been signed by the atter page 2 should be detached for u	ed by PI	Part II. Other signi	ficant condit	ions con	tributing to death t	ut not res	ulting in the u	ınderlyin	g cause giv	en in Part	l.			Α.	to the cause of deat Probably 4 □Unk	
		Completed			<u>_</u> _								24a. Wa auto per Yes	opsy formed?	prior to	autopsy findings ava completion of caus s 2 No	ilable e of
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	g	Certification:	27. Manner of Dea 1 Vatural 2 Accident 3 Suicide 4 Homicide	5 Pendi invest 6 Could	igation	28a. Date of Inju (Month, Da 28e. Place of In building, e	y Year)		М		yat k? Yes 2□] No	28d. Describe 28f. Location City or To	(Street	and Number or I	Rural Route Number	
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	Sta Regist		31. Date filed (Mor) 13 '	32. Regis	ar's Signa	iture #	Soo	1. 1							

DHMH 17 Rev 1/2001

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Medi/ Examir		4a. Fecility Name (THIRV	4b. City, Town	n, or Loca	ation of Deat			4c. County			
		30127 MA	TTHEWS'	TOWN F				EASTON					TALBO)T		
ral		5. Social Security N		6. Sex	7. A		last birthday Yrs.	Months Da		Jnder 24 Hrs ours Min.	. (Month	, Day, Yea		Col	place (State untry)	or Foreig
r		278-82-4 Usual Residence of		7		24	115.				JUNE	21,	1981	(OHIO	
		10a. State	10b. Count	у		10c. Ci	ty, Town or L	ocation.							10d. Inside C	ity Limi
	ctor	OHIO	WASH	INGTON	N		1	MARIETTA							1 X Yes	2 🗆 N
	Director	10e. Street and Nu	ımber					10f. Zip Cod	le			10g. (Citizen of \	What Cou	intry?	
	2	208	CLARK						4575					.S.A		
	Funeral	11. Marital Status			Was Deceden Armed Forces	?	.S. 13	Was Decedent of If Yes, specify C	of Hispan Juban, Me	ic Origin? (S exican, Puer	Specify Yes o to Rican, etc	r No-)		e - Amer ck, White	ican Indian, , etc.	
	by F	1 X Never Mari 3 ☐ Widowed		rnea d	1♥ Yes 2 ☐ If Yes, Give Year or Dates:			1 ☐ Yes 2√7!	No Sp	ecify:			Specify	v: WHI	TTE	
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	Be	17. Father's Name	(First, Middle	, Last)					18. !	Mother's Na	me (First, Mi	ddle, Maid	en Surnan	ne)		
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Amend item#1, perMD, C846, 8/24/05 TT
State of Maryland / Department of Health and Mental Hygiene

Amend Item 1 per dr., G846, 08/22/05dhb
Certificate of Death

Reg. No. 20 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mahala Susan Obitts Month Day Vac **Physician** 2:05 AM 2005 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 (\$20)F Yrs. Director 67 June 12,1938 Maryland 219-34-5531 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts 28e-f show other traumatic event, the Medical Examiner must be nutified at 1 Yes 2 No Director Washington Williamsport Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Items 23a 15621 Clear Spring Road

Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Never Married

3 ☐ Widowed 4 ☐ Divorced

1 ☐ Yes Give Year or Dates: 21795 USA death by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married Married ö 1 ☐ Yes 2XXNo Specify: Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rayn jujury or other traumatic event, it is Med 9008. College (1-4or 5+) Elementary/Secondary (0-12) 10 Housewife Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Samuel Nichols Grace Louise Mowen Elmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11966 Ernstville Rd. Big Pool, Maryland 21711 Donna Bair - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

XXBurial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park | July 2,2005 | Williamsport, Maryland of Funeral Service Licensee Osborne Tunerally Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lospe disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last euk Due to (or as a consequence of): Examiner Hypoxie certificate be executed use as the burial-transi the attending physician and as a consequence of): ision of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 \ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours all To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number see M.D. 4-05 62440 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mod East Antuta 251 31. Date filed (Month, Day, Year) 32. Paristrar's Signature State JUL 0 5 2005 Registrar

			For State Registrar	State of M	Maryland / (artmen			and Me	ental Hy	giene	200	5	23428	
			Decedent's Name (First, Middle, I	Last)						1	2. Date of D			ar	3. Time of Death	
	Physicia /Medic		Thomas Gilmore	Pownall							June 2		005		11:30P ^M	
	Examin		4a. Facility Name (If not institution, g	4b. City,	city, Town, or Location of Death 4c. County of Death											
			Manor Care Potomac 5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If							24 Hrs.	Data of D		ntgom		ace (State or Foreign	
	Funeral Director		5. Social Security Number 6 6 235-20-1348	.Sex 7 1X□M 2□F	Age (In yrs. last bii 83	Yrs.	Months	Days	Hours	Min.	B. Date of B (Month, D Jan。 2	ay, Year)		Coun	land	
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315-0036	J within 72 hours after death with the Marylan ilean. Itan "neturel", or Items 23a or 28e-f show Ita Medical Examinet must be rudified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) (Chairman and CEO of the Aerospa									ess/Ind	lustry			
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Maryland	Mental Mental arked o	To B	Hetzel Pownall								Wolfe					
lan.	as 1 and 2 should b of Health and Ment item 27 is marked rother treumatic		19a. Informant's Name/Relationship				-				Route Num					
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Box	ath itter	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1										23d. Date of delivery Month Day Year			
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Records,	taw r	Completed									24a. Wa	s an opsy formed?	24b. Wei	re auto	psy findings available npletion of cause of	
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Vita	nysician: The la nis certificate has I director, page 2	Be c	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No	Hospital: 1 Inp	patient 2 ER/O	utantio	nt 3 D	Oth			<i>(Check onl</i>) ne 5 ☐ Re		6 □Other	Snacif	/1	
o	~ = a	n: To	27. Manner of Death	28a. Date of		Time o		28c. Injur Wor			8d. Describ			Specii	,	
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	Nithin Fo the Somple	Me	29b. Signature and title of certifier				29	c. Licens	e number			29d. Da	te signed (/	Month.	Day, Year)	
	10) per				0	00	545	66		61	25/	05		
	10		30. Name and address of person w	no completed cause	of death (Item 23a)	(Туре,	, Print)			.,		_	2 I		212-98	
			31. Date filed (Month, Day, Year)	uli 122	A Each	00	Pro P	Sacre	1 50	ee42	250	1000	15510,1	71)	4-10	
1	Sta Regist	ate rar	JUL 01	2005	gistrar's Signature	S.	BALL.	9	*							
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			State of Maryland / Departm State of Maryland / Departm Certific	ent of Health and M ate of Death		iene	231.20						
			Decedent's Name (First, Middle, Last)		2. Date of Deat	th	3. Time of Death						
	Physicia		JULIO CESAR PORRAS		Month June	22 2005	9:15 P M						
	/Medid Examin		· · · · · · · · · · · · · · · · · · ·	city, Town, or Location of Death		4c. County of Deat	h						
	LAGIIIII	Ŭ.	1201 Parrs Ridge Drive S	pencerville		Montgom	ery						
	Funeral		Mon	nder 1 Year If Under 24 Hrs. hs Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birti	hplace (State or Foreign untry)						
	Director		214.42.3195 72 Yrs.		Feb. 15,								
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits						
	Aaryli f sho	5	Maryland Montgomery Spencervill	0			1⊠Yes 2□No						
	28a-	rec		Zip Code	1	0g. Citizen of What Co	untry?						
	3a or		1201 Parrs Ridge Drive	20868		U.S.A.							
	death ms 2	Funeral Director		ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - Ame Black, White							
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Madigal Examahar must be notified at	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:										
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72	within ene.	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	Carpenter		Homes Remo	deling						
	Hilled Hygi other ent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M								
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Maryland	should and a summan		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	ress (Street and Number or Rura	i Route Number	; City or Town, State, 2	Zip Code)						
	and 2 ealth n 27 l			rs Ridge Drive	-								
ore	H iter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crematory			20c. Location - City or							
Baltimore,	treen tant:			Crematory 6/2	9/2005 1	Brentwood,	Maryland						
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury ago of the traumatic event, its medical Evan incrnist are rollified at once.		Nacy A. Pacenty 11800	e and Address of Facility S-RINALDI FUNERA) New Hampshire	AL HOME. Ave, Si	INC. Llver Sprin	ig, MD 20904						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between										
E	Physician		Immediate Cause (Final disease or condition as Coronary Artery Disea	se			Years						
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oʻ	exec an an rial-tr	Еха	resulting in death) Last Due to (or as a consequence of):										
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Вох	eath certific attending p i for use as I	lan/		ic pregnancy		23d. Date of delivery Month Day Year tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Klunknown an 24b. Were autopsy findings available							
o <u>.</u>		ysic	1 Yes 2 No 9 Unknown	(specify)									
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rds,	w requires tha been signed I should be det	ed by			1 □ Ye	es 2□No 3□Pr	obably 4XUnknown						
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Vital	certificate	Be C	25. Was case referred to medical	26. Place of Death									
of V	S = B	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3		me 5፟ ⊠ Reside	ence 6 Other (Spe	cify)						
n 0			27. Manner of Death 1 ☒ Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury	Work?	28d. Describe ho	ow injury occurred							
sio	Attending r death. ector: After by the fune	cat	2 Accident investigation M 3 Suicide 6 Could not be Record Injury At home form street fa	1 Yes 2 No	Of Location (St	treet and Number or Ru	ural Route Number						
Division		ertification;	4 Homicide determined determined determined determined building, etc. (Specify)	ctory, office	City or Town		na riodie ramber,						
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occu 2 Medicel Exeminer: On the basis of examination and/or investigations and manner stated.										
	To the within 2 To the complet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Monti	h, Day, Year)						
	⊢ s ⊢ ŏ		· // X V/MMD	D-38457		June 29, 2	2005						
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				00000						
			Nakul Goyal, M.D., 3801 International	Drive, Suite #	211, Si	lver Spring	g,MD 20906						
			31. Date filed (Month, Day, Year) JUL 01 2005 33 Registrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 23a per doc 9846 8-10-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JUNE Day Year **Physician** 1:17 PM John Henry Preston Sr. 2005 /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. If Under 1 Year Min. Months Days Hours Min. April 8, 1941 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊡**M 2□ F 459-66-6930 64 Yrs. Houston. Texas Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or Items 23a or 28a-f show other count be notified at 1 XYes 2 ☐ No Director Washington <u>Hagerstown</u> MD10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 USA 435 N. Jonathan St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: the Mucical Exam Black Completed by 3 ☐ Widowed 4 ☐ Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Manufacturing 12th Machine Operator 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is markad ofth any injury or other traumatic avant, 2008: 17. Father's Name (First, Middle, Last) Be Katherine (Unknown) Charlie Preston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 435 N. Jonathan St. Hagerstown, MD 21740 <u>Hazel J. Preston / Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State July 2, 2005 Hagerstown, MD Cedarlawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Eugeral Service Livensee Gerald N. Minnich Funeral Home 305 N. Potomac St. Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a donsequence of): Examiner -transit Physician: The taw requires that the death certificate be executed and Due to (or as a consequence of) physician a s the burial-Records, P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 200 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 10 Inpatient 2 ER/Outpatient 3 DOA ၉ Division of 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: After or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funaral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mi) du 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GH-20+1

State Registrar 31. Date filed (Month, Day, Year)

JUL 01 2005

GHMAY

1190 MT NOWN ROAD

32. Degistrar's Signature

Discussion B. Specker

			For State Registrar	State o	of Marylan	-	artmen tificate			and M		g. Ng	05	231	31	
ı	Dhysicis	Decedent's Name (First, Middle, Last) Physician										h Day	Year	3. Time bi	f Death	
	/Medic		Debra		Perrin July 7, 4b. City, Town, or Location of Death 4c. Col						2005	1:00 /	4 M			
	Examin	er	4a. Facility Name (If not institution		mber)		4b. City,		Location of Lumber			4c. Cour	nty of Death Allegan	nv.		
			416 Louisiana A	6. Søx	7. Age (In yrs.	last birthdav)	If Under		If Under		8. Date of Birth			place (State o	or Foreian	
	Funeral Director		216-72-6260	1□M 2፟DF				Days	Hours	Min.	(Month, Day, 07/30/19		Mary	ntry)		
			Usual Residence of Decedent								_011.301.12					
	show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo			1					10d. Inside C	ity Limits 2 \(\sum \text{No}	
	Sa-f.	Director		.legany				erlan	<u> </u>		4	0g. Citizen o	4 1945 - 4 0 -			
	with ti	ă	10e. Street and Number 416 Louisiana	Avenue			10f. Zip	215	02		"	USA	or wonat Cou	ntry !		
	death with the Maryland rms 23a or 28a-f show	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	l.S. 13. V	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)	14. R	ace - Am <i>e</i> n	can Indian,		
٥	or iten	Fun	1 Never Married 2 Marri	Amed F ed 1 ☐ Yes	orces? 2⊠No	i	fYes,speo 1□Y <i>e</i> s				Rican, etc.)		lack, White,	etc.		
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9500-GLZ	in 72 hours after death with the Marylan "natural, or items 23a or 28a-f show tedical Examinat institut at	lete	15. Decedent (Specify only highes	(Give	Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry											
7	filed within 72 hours after Hygiene. ther than "natural", or ite ant, tre Medical Examire	Completed	Elementary/Secondary (0-12)	<i>m</i> 0. <i>u</i>	Laborer Landscaping											
N D		0	17. Father's Name (First, Middle,				18. Mothe	er's Name	(First, Middle, N	Aaiden Sum	ame)					
yland		To B	Presley	Eugene	2	Pe	errin			Anna		Clara Chamberlain				
, mary	2 should be and Mental is marked aumatic ev	_	19a. Informant's Name/Relations	nip (Type, Print)			-				I Route Number			o Code)	99	
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic elongs.		Patricia Lease / sister 1016 Brown Avenue, Cumberland, Maryland 21502 20a. Method of Disposition 20b. Place of Disposition (Name of commetery, crematory or other place) 20c. Location - City or Town													
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g	Departimbe		1 1 11	h	lan						mberland,		-			
			shock, or heart failure. List	3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										ween		
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Division	or Att	Certification;	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 289. Plac	e of Injury - At h ding, etc. (Speci		eet, factor	ctory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)					nber,			
	ppitai ours a ierai [29a. Certifier Certifyin	g Physicien: To th	e hest of my kni	owledge deat	h occurred	at the tim	e date ar	nd place	and due to the ca	use(s) and	manner as s	stated.		
	To the Hospital within 24 hours or To the Funeral completely filled	edical		Examiner: On the											5)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr	Me	29b. Signature and title of certifie		/		290	. License	number		2	9d. Date sig	ned (Month,	Day, Year)		
l	5'			00				D0	023371	L		July	7, 200)5		
	211		30. Name and address of person Qamar U. Zama	·	ise of death (Ite 625 Kent			rland	. Mar	land	21502					
	nfed	to	31. Date filed (Month, Day, Year)	32	Registrar's Sign.	atura				,						
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	*	3	Registrar 1. Decedent's Name (First, Middle, La	st)			, timou			2. Date of Do			3. Time of Death	
	Physicia /Medic		TYLER WILLIAM	PEARCE						July	09	200	5 10:50 P M	
	Examin		4a. Facility Name (If not institution, given				4b. City	, Town, or Loca	ation of Death	•	4c	. County of De		
2	Formula		Washington Coun 5. Social Security Number 6.5	y Hospit	al Age (In yrs.	last birthday			Jnder 24 Hrs.	8. Date of Bi	rth Value	Washin	inhplace (State or Foreign	
, and	Funeral Director		213-11-9999	X M 2□F	22	Yrs.	Months	Days Ho	ours Min.	SEPT •	ау, ^{үөаг} ,	L982 '	MARYLAND	
at .	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or I	Location						10d. Inside City Limits	
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other then "natural", or items 23a or 28a-f ehow unafte event, the Medical Exercition can be notified at	to	MARYLAND WASHIN	ВОО	NSBORO				1 Yes 2 No					
	or 288	Director	10e. Street and Number				10f. Z	p Code			10g. Ci	tizen of What		
	ath wi		21411 KEADLE ROA		net Ever in I	10 12	Was Das		1713	ecify Yes or N	0*		S.A.	
	ter de	Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decede Armed Force 1 ☐ Yes 2	əs?).5.	If Yes, sp	ecify Cuban, M	exican, Puerto	Rican, etc.)		Black, Wi		
036	rai', or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:		1 🗆 Yes	2 X No Sp	pecify:			Specify: WHITE		
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D	e filed al Hygi other vent,	BeC	17. Father's Name (First, Middle, Las)				18.	Mother's Nam	e (First, Middle	e, Maider	Sumame)		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hc I Health and Mental Hyglene. Item 27 ie marked other than "natuu other traumatic event, I'm Medical	5	ROBERT WILLIAM PEARCE LESA DAWN BROADSTONE 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, S										ata. Zin Codo)	
Mar	2 2 2		19a. Informant's Name/Relationship ROBERT W. PEARCE/			1	•			NSBORO,			21713	
_	permit. Pages 1 and Department of Health important: if item 27 any injury or other it		20a. Method of Disposition			Place of Disposery, cr	position (Na	ame of		Date	-		or Town, State	
E O	Pages nent o int: if		1 ☐ Burial 2 🖾 Cremation 3 L 4 ☐ Donation 5 ☐ Other (Spec		ate		-	REMATOR	Y 7/14	+/2005	SMI	THSBURG	G, MARYLAND	
Baltimore,	epartn epartn nports ny injv		21. Signature of Funeral & Course	Paul	M. De			and Address of UNERAL	DICAMIE.	7606 01				
	20539	_	23a. Part 1. Enter the disease, or cor							Boonsbo		Maryla	nd 21713 Approximate	
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3760,	ificate be executed g physicien and as the burial-transit	lical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Division of Vital Records, P.O. Box 68760,	ne death cer the ettendin thed for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fet nt at time of	al death 3	3 □Ectopic 5 □ Other (23d. Date of Month		
S,	ss that the	by Pr	Part II. Other significant conditions	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cau		
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V Its	sician certifi irector	Be C	25. Was case referred to medical examiner? 1½ Yes 2 No	Hospital:	nationt 26	X ER/Outpat	ient 3 1	Other		th <i>(Check only</i> ome 5 ☐ Re		6 □Other (S	inecify)	
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	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director, Atter this certificate ha completely filled in by the funeral director, page	Medical Co										r as stated. due to the cause(s)		
	o the ithin 2 o the omple	Med	29b. Signardra and itle of certifier	and manner stated. 29b. Signatura and title of certifier 29c. License nu							29d. Date signed (Month, Dey, Year)			
	- s - ō		1 Levels	and)				OCM	Œ		Jul	y 10,	2005	
			30. Name and address of person wh	completed cause		əm 23a) (Typ	pe, Print)	Penn S	treet	Baltim			and 21201	
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	Regist	rar	JUL 1 6	ZUUD A	28:12 1	K	Chille 4							

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ORIGINAL

			1 - For State Registrar	State of M	Marylan		artment <i>rtificate</i>			nd Me		giene Reg. NQ	NNE	201	2.0
			Decedent's Name (First, Middle, La.	st)						2	. Date of Dea	100	UUJ	3. Time of	Death
	Physici	an	Jeffrey Alan Pac	re							Month June 2	Day	Year	12:40	M a
	/Medic		4a. Facility Name (If not institution, giv		er)		4b. City. T	Town, or	Location of		June -	_	County of Dea		
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_	Funeral		5. Social Security Number 6. S			last birthday)	If Under	1 Year	If Under 24	4 Hrs. 8	. Date of Birt	h .	9. Biri	thplace (State of	r Foreign
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			Usual Residence of Decedent				1				dron 2	· , _	334 11	CW CCIB	
	ylan		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Cit	ty Limits
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	or 28	Director	10e. Street and Number	-			10f. Zip	Code				10g. Citiz	zen of What Co	ountry?	
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	eea	Funeral	11. Marital Status	12. Was Decede Armed Force			Was Decede	ent of Hi	spanic Origi n, Mexican,	in? (Specif	fy Yes or No-	1	14. Race - Ame Black, Whit		
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8	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examinat trust be rudified at	d by	3 Widowed 4 Divorced	Year or Date	S:										
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121	filed v Hygie other 1		17. Father's Name (First, Middle, Last)		Nev	VET WC	Trec		's Namo /	First, Middle,	Maiden		N/A	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "naturat", or Items 23a or 28a-f show contine traumatic event. The Medical Examinet must be notified at	Be	Louis A. Page							,	an Moo		Jonano		
ž	d Me nark naric	٦	19a. Informant's Name/Relationship (Tuna Print)		10h Mailie	a Address	(Street 2					Town, State,	Zin Codo)	
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	Heal Heal Her	113	Louis A. Page/ 20a. Method of Disposition	rather	20b. P	lace of Dispo			ı Lane	Dat			PA 1904 cation - City or		
٥	ages		t ☐ Burial 2 🖾 🕏 remation 3 🗆		te c	emetery, crer. ropolita	natory or ot	her place		June					
Baltimore,	it. Perriment ritant ritant njuri	113	 4 □ Donation 5 □ Other (Special 21. Signature of Fineral Service Lice 		risu					20				, Virgir	nia
Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		11 60%	amesy	,						uneral W., S			ng, MD 2	20901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	ed the deat									Approximate Interval Bety	8
W.	Pnysician	F 1	Immediate Cause (Final disease or condition											Onset and D	
	/Medical		resulting in death)	a Pneumo Due to (or	as a conseq	uence of):									
н	Examiner			b. Genera	al Deb	oility									
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a conseq	uence of):									
	cuted	Examine	that initiated events	С.											
o,	an ar	EX	resulting in death) Last	Due to (or	as a conseq	uence of):									
68760,	cate be executed physician and the burial-transit	dical		d											
_		w	IF FEMALE:												
Вох	th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth			Ectopic pre	egnancy				2	3d. Date of de	,	/ear
	e dea	Physician/M	1 ☐ Yes 2 ☐ No	4□Pregnant 9□Unknowr		eath 5□	Other (spe	ecify)				İ	WORLD	Day 1	oai
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Ö	law las be	ple									24a. Was autop	SV	prior to	utopsy findings a completion of ca	available ause of
- B	The ate h page	Con									perfor		death?	2 No	
/ita	sian: ertific ector,	Be	25. Was case referred to medical examiner?							of Death (0	Check only o	ne)			
of Vital	Physician: this certific ral director,	10	1 ☐ Yes 2 X No	Hospital: 1 Inpa		ER/Outpatien		1	4 D INUIS				Other (Spe	cify)	
		on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of II (Month, I	njury Da <i>y Year)</i>	28b. Time of Injury		Bc. Injury Work			d. Describe h	ow injury	occurred		
Sio	uttendii death. ctor: A y the fu	catl	2 ☐ Accident investigation				М		/es 2 □ N						
Division	or Att	Certification:	3 Suicide 6 Could not be determined	286. Place of	Injury - At he etc. (Specif	ome, farm, str y)	eet, factory,	, office		281	f. Location (S City or Tow	itreet and m, State)	Number or Ri	ural Route Numi	ber,
	urs al														
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical		nysician: To the be miner: On the basis and manner	of examina)
	o the ithin o the omple	Me	29b. Signature and title of certifier	21.0 110111101		9	29c.	License	number			29d. Date	signed (Mont	h, Day, Year)	
	F 3 F 8		Saima	Ch	200	1al			965					ie 29, 2	2005
	3		30. Name and address of person who	completed cause a	doath (Itea	n 28a) #Tune	Prin*1								
			Saima Khawaja,M.	D. 11119	Rock	ville	Pike,	Sui	te 10	0, Ro	ockvil	le, I	MD 208	352	
	Sta Regist		31. Date filed (Month, Day, Year) JUN 3 0 2	005 32 Regi	strar's Signa	f. Ag	sele?								

		Please	e Type or Print				=		.egible.		
		For	State of Mar	•	partment of H		_	_	000		
		1 - State Registrar			ertificate of	Death	1	Reg. No	005	234	34
Phys	ician	Decedent's Name (First, Middle, L.	.ast)	T) 4/14		2. Date of De Month	Day	Year	3. Time of D	
/Me	dical	DOROTHY	Virgin	iat	TTNIAL	Location of Deatl	JUN		2005 ounty of Death		HM
Exar	niner	4a. Facility Name (If not institution, gi	1 Care C	210-1-210	46. City, Town, of	01.	1		Talbor		
Funer	ral .		Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year	STOW If Under 24 Hrs.	8. Date of Bir (Month, Da			place (State or i	Foreign
Direct		218-10-7340	1□M 202F	82 Yrs	Months Days	Hours Min.	APril 2	y, year)	23 MG	arylan	12
pu ,		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or	Longtion			7		10d. Inside City	Limite
anyla	5			~ .						1 TYes 2	
the N	Director	MD Tall	bot	STI	Michael 101. Zip Code	5		10a, Citize	en of What Cou	untry?	
death with the Maryland ms 23a or 28e-f show	ā	232 Dods	On AVEY	LIP	2.11	63			11 < A		
death ms 2	Funerai	11. Marital Status	12. Was Decedent Ev	er in U.S. 1	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No	- 14	4. Race - Amer		
after or ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	o moan, etc.)		Black, White	, etc.	
13-UU36 172 hours after "neturel; or Ite	d b		Year or Dates:						310	zck	
1Z13-UU30 within 72 hours after death with the Marylan hale. than "neturel; or items 23a or 28e-1 show widel Exam as investigation."	Completed	15. Decedent's E (Specify only highest g	Education grade completed)	16a. De (G	cedent's Usual Occup ive kind of work done o e. DO NOT use retired	ation during most of wor d)	rking	16b. Kind	d of Business/li	ndustry	
d Z1Z13- filed within 72 Hygiene. ther than "net	ome o	Elementary/Secondary (0-12)	College (1-4or 5+)		omest			PR:	vote 1	Resider	nce
illed Hyg other	Be	17. Father's Name (First, Middle, Las	st)		0/0/031	18. Mother's Nar	ne (First, Middle			103.00	
Maryland d 2 should be file th and Mental Hy 7 is marked oth treumetic event	To B	Albert 6	Enos M	100dy		Lor	a N	1:116	PR		
Taryla 2 should and Men 1s marke		19a. Informant's Name/Relationship	(Type, Print)	18b. M	ailing Address (Street		1 2 3				, , -
_ c = ~ L			chols		Mitchell	St. Apt	2B St.	MC	haels,1	UD.210	063
Baltimore, Dermit. Pages 1 a Department of Hec mportent: If Item eny injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	cemetery,	sposition (Name of crematory or other place	1 00/			ation - City or T		
Saltim permit. Pag Department Importent:		 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice 		thomas	Mem. Ceme		1/05	Stil	1.cha	els, M	\mathcal{D}_{-}
Balt permit. Departit Importe eny injk	once	1 1 1	- //	2	11000011	4.0-11	toMe, P.	4.)A	10 716	12
		23a. Party. Enter the disease, or conshock, or heart failure. List only	emplications that caused the	ne death. Do not	enter the mede of dying	hington ng, such as cardia	or respiratory a	rrest,	dee a	Approximate	
Physicia	212	Immediate Cause (Final	ly one cause on each line.	Anni	return 1.	neur	Mu			Interval Between Onset and De	e a (h
/Medic	al	disease or condition resulting in death)	aDue to (or as a	consequence of):	word /	70000 1.) Colect	7
Examin	er	Sequentially list conditions	b								
D tr	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a d	consequence of):							
60, be executed sician and burial-transi	xam	that initiated events resulting in death) Last	cDue to (or as a	consequence of):							
	70			,							
I Hecords, P.O. Box 68/6 The law requires that the death certificate tate has been signed by the attending physic age 2 should be deteched for use as the	Completed by Physician/Medic		d								
h cert	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2	pregnancy	3 Ectopic pregnancy			23	3d. Date of deliv	/ery	
death death	Cla	in the past 12 months?	4 Pregnant at tir		5 Other (specify)				Month	Day Ye	ar
F.O.	Phys	9 Unknown				i- D. al	22a Dide		tribute to	the serves of do	nth?
IS, F res that signed to be det	۵	Part II. Other significant conditions	A Continbuting to death but	not resulting in th	e underlying cause giv	en in Part I.		Yes 2 🛭		the cause of dea bably 4 ⊟Un	
ecord: taw require tas been sig	eted	A P. J.	0 B=0==V	00 /	2 hd.			1			
al Rec : The law cate has b	, la	15 Cagera	K FREIW KNOW	a cung	wissen		24a. Was autop perfo		prior to co death?	opsy findings av ompletion of cau	use of
	ပိ		rigecoma			Of Place of Day	1 ☐ Yes	28 No	1 🗆 Yes	2 🗆 No	
Vita rsicien: s certific director,	o Be	1 ☐ Yes 2 🕱 No	Hospital:	2 ER/Outpa	itient 3 DOA Oth	0.00	lome 5□ Resi		□Other (Speci	ifv)	
g Physical this peral di	<u> </u>		28a. Date of Injury (Month, Day)	28b. Tim	e of 28c. Injur	v at	28d. Describe			,	
endir eath. or: Af	atic	1 Natural 5 Pending 2 Accident investigati	tion			Yes 2 □ No					
DIVISION OF I or Attending Phy atter death. Director: After this in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, farm, (Specify)	street, factory, office		28f. Location (Number or Rui	ral Route Numbe	er,
pitel curs at arel D	S		Dharatai an Tarka bara at							-1-1-1	
Hosj 24 ho Fund	edical	29a. Certifier 1 Certifying F (Check only 2 Medicel Exc	Physicien: To the best of eminer: On the basis of e and manner state	xamination and/o							
Division of Vita within the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier	/ /	0.0	29c. Licens	e number		29d. Date	signed (Month,	, Day, Year)	
⊢ ≩ ⊢ ŏ		▶ Wellea	m Hwoa	de Mi	Do	08715		6	25/0	15	
		30. Name and address of person who	no completed cause of dea	th (Item 23a) (Ty	pe, Print)				/		
		William H. Wood,			Hill Care	Center,	501 Dut	chman	's Lane	e, Easto	on MI
	State		9 2005 32. Reofetrar	s Signature	A. Au						
Reg	istrar	Section 18		ALP ALP							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mar	ylan				ealth a	and M	R	g. NQ. (0.05	23435
ı	Physici		1. Decedent's Name (First, Middle, Last) Nancy A. Rose	nbaum							2. Date of Deat June	30°,	20 ⁶ 5	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give 919 Brentwood L						Location of				unty of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (in yrs.	last birthday)	If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birth		ntgom	alaaa (Ctata aa Saasi a
	Director		071-30-2621 15 Usuel Residence of Decedent]м 2ДF	9	5 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Jan. 1,	1910) New	ntry)
	ryland how		10a. State 10b. County		0c. Cit	y, Town or Lo								10d. Inside City Limits
	the Ma	ector	Maryland Montgome	ry		Silve:						D- Civi	-6145 + 2	1 ☐ Yes 2 No
	h with	ai Dir	919 Brentwood Lan	e			10f. Zip		20902	2	'		of What Cou ed Sta	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel', or Items 23a or 28a-1 ehow important: If item 27 is marked other then "naturel', or Item death of the marked elow in the Maryland Item of Item of the confiler at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.	ı	Was Dece f Yes, spe		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: Wh	
5-0	"natur	leted	15. Decedent's Edu (Specify only highest grade	cation completed)		16a. Deced	kind of wo	rk done a	uring most	of worki	ng	16b. Kind	of Business/In	dustry
21215-0036	d withir giene. er then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	4	Secre	oo not u tary	se reurea,	,			Scho	ol Sys	tem
	I be filed ntal Hygi ed other event, L	Be	17. Father's Name (First, Middle, Last) ISaac	Ado.	lnh				18. Mothe		(First, Middle, A			
Maryland	should Ind Men	2	19a. Informant's Name/Relationship (Ty)	pe, Print)	- Lvi	19b. Mailin	g Address	(Street a			I Route Number,	City or To		Code)
	1 and 2 Health a sm 27 to		Carol Rabin –daugh		20h B						-			nd 20902
altimore,	Pages nent of h ant: If its		1 Ø Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Bei	lace of Dispo- emetery, cren th Dav:	id Ce	other place mete	ry 7	/1/2			ion - City or To .t, New	
Balti	permit. Departm Importe any inju		21. Signature of Faur 1 Service Licente		//) 22 D	. Name ar	nd Addres	s of Facility Borgw	ardt	Funeral	Home	e. PA	yland 20705
	Icate be executed /Medical Examiner The pural-transit The pural-tr	dical Examiner	23a. Part1. Enter the disease, or complishock of heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequ	Arestuence of): Level annual off	+ 6	ilac	, such as	cardiac	respiratory arre	st,		Approximate Interval Between Onset and Death Multing
P.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown Part II. Other significant conditions con	3c. If yes, outcome of particles of the program of the program of the program of the put	Fetal	death 3 = 5	Ectopic pi	oecity)	n in Part I		23e. Did tob		Date of delive	ery Day Year
rds,	quires l	ed by	de Condition			3.1.1.g 11 11 10 G		ausa giva						ably 4 Unknown
Division of Vital Records,	ician: The law re certificate has bee rector, page 2 sho	Completed		eros.y							24a. Was ar autopsy perform 1 \(\text{Yes} \) 2		prior to cor death?	psy findings available inpletion of cause of
<u> </u>	ysicial is certification	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🜠 To	ospital:	2 🗆	ER/Outpatient	3 DC	Othe			(Check only one ne 5 ⊁ Reside		Other (Specifi	/)
sion of	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification; T	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Ye	ear)	28b. Time of Injury		8c. Injury Work		2	8d. Describe ho			,
DIVI	ospitel or Attenchous after death hours after death unerel Director: ly filled in by the		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (S	Specify	′)					8f. Location (Str. City or Town,	State)		
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Exemin	icien: To the best of m ter: On the basis of ex and manner stated	aminat	wledge, death ion and/or inv	occurred estigation	at the time , in my op	e, date and inion, deat	l place, a h occurre	nd due to the ca ed at the time, da	use(s) and te and pla	d manner as st ce, and due to	ated. the cause(s)
	To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier	A RATIN	^			. License	06		29	. /	gned (Month,	
	12		30. Name and address of person who co	M-M) ltom	23a) (Tuno 1		1008	1667			6/	30/05	
			Ira Y. Rabin, M.I	. KP 10810	Co	nnecti	cut i	Avenu	ie Kei	nsing	gton, Ma	rylar	nd 2089	5
	Sta Registra	_	31. Date filed (Month, Day, Year) 3UL 0 1 200	3 Registrar's	Signat	ture	de l							

			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of F		, ,			
	Physic		1. Decedent's Name (First, Middle,	Robertson				2. Date of Deat Month June 29	D	95 2 13 9 D	316 P M
	/Medi Exami		4a. Facility Name (If not institution, Homewood at Cr		ns		r Location of Deat		4c. County of		
ŀ	Funeral Director		5. Social Security Number 213-16-4376 Usual Residence of Decedent	. Sex 7. Ag 1 □ M 2 1 F	e (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 1920	9. Birthplace (State or F Country) Maryland	-oreign
	with the Maryland a or 28a-f show	tor	10a. State 10b. County	erick	10c. City, Town or Lo					10d. Inside City I	
	with the 3a or 28a	Funeral Director	10e. Street and Number 7407 Willow Ro	ad, A-305	1	10f. Zip Code	21702	1	Og. Citizen of W	hat Country?	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiane. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show any july or other treumatic event, the Medical Evant and must be notified at once.	d by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 № No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race	- American Indian, , White, etc.	
21215-0036	i within 72 ho liane. r than "netu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4or 5	(Give	dent's Usual Occup kind of work done o DO NOT use relired emaker	during most of wor	rking	16b. Kind of Bus	,	
Maryland 2	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, La Roland Natha	st)			Laura	ne (First, Middle, M		,	
, Mar	and 2 shi ealth and m 27 Is m		19a. Informant's Name/Relationship Judith R. Nieb		hter 126	95 Monnie		ral Route Number, Mt. Air		State, Zip Code) 21771	
Baltimore,	Pages 1 tment of H tant: If ite	,	20a. Method of Disposition 1 □ Burial 2 ② Cremation 3 1 □ Donation 5 □ Other (Spe	cify)	-	sition (Name of natory or other plac itan Cren	·	Date 2		City or Town, State dria, Va.	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Lic	V. Barl	rer	P. O. E	H. Barber Box 5038.	Funeral Laytons	ville,	Md. 20882	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or oc shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each lir	the death. Do not enti- e. a consequence of):	er the mode of dyin		or respiratory arre		Approximate Interval Betwee Onset and Dea	
8760,	icate be executed physician and sthe burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Emer uncertying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
9	ertificate ling phys ie as the	Medicai	IF FEMALE:	d							
.O. Box	The law requires that the death certific tle has been signed by the attending p page 2 should be detached for use as:	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Monti	,	r
Records, P	w requires that been signed I should be det	þ	Part II. Other significant conditions	contributing to death bu	it not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob		oute to the cause of death	
al Rec		Completed	HUDECT	ension				24a. Was an autopsy perform 1 \(\text{Yes} \)	gd? de	ere autopsy findings avair or to completion of cause ath? Yes 2 \(\text{No} \)	ilable e of
of Vital	S S P	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatie			er: 4 🗆 Nursing H	th <i>(Check only one</i> ome 5 🗆 Resider	nce 6 SOther		4
Division	Attending r death. ector: After by the funer	Certification:	27. Manner of Death Autural Calculation C	be One Olean of Init	ry - At home, farm, stre		rat :? Yes 2 □ No	28f. Location (Stree City or Town,	eet and Number	or Rural Route Number,)
_	To the Hospitel or Within 24 hours afte To the Funerel Dire completely filled in b	edical C	29a. Certifier (Check only one) Certifying Page 2 Medical Exp	thysician: To the best of the basis of afficians of the basis of afficiant and an armonic star and an armonic star afficial and an armonic star and armonic star and armonic star armonic s	examination and/or inv	occurred at the tim estigation, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and mann e and place, an	ier as stated. d due to the cause(s)	
)	To the complet	Me	29b. Signature and fille of certifier	/him	10	29c. License			d. Date signed (June 30,	Month, Dey, Year) 2005	
				E, III, M.I	300	W. 9th S!	r., FREI	DERICK, M	D. 217	01	
	Sta		31. Date filed (Month, Day, Year)	32 Registra	r's Signature	ule"					

			1 - For State Registrar	State	of Marylan		artment of rtificate o				jiene	005	231.37
	Physici	on	1. Decedent's Name (First, Middle, La	st)						2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	cal	HAZEL LENORE RAY				4h Cih. Taum	ar Lagation	of Death	June	T	2005 County of Death	9:03 P M
п	Examin	ıer	4a. Facility Name (If not institution, giv				4b. City, Town			M.d			2
	Funeral		Salisbury Nursir 5. Social Security Number 6. S	ΘX	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Unde	r 24 Hrs.	ry, Md. 8. Date of Birth (Month, Day) 12-07-1		Wicomico 9. Birth	place (State or Foreign ntry)
н	Director		213 24 0070	□M 2□F	7	5 Yrs.	World Day	3 Hours		12-07-1	929	SILO	AM, MARYLAN
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	h the Maryland rr 28a-f show	tor	MD WICOM	ICO	S	ALISBU	RY						Y∏Yes 2 No
	or 28	Directo	10e. Street and Number				10f. Zip Code			1	0g. Citiz	en of What Cou	ntry?
	72 hours after deeth with the Maryland Inatural, or Iteme 23a or 28a-f show Vical Examitive in the institlied at	rai	917 HANOVER STREE		ecedent Ever in U	S 12	Man Danadant a	2180		ody Voc or No-	1	USA 4. Race - Ameri	can Indian
	fter de ritem	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed 1 ☐ Yes	Forces? s 2∭ No				an, Puerto	ecify Yes or No- Rican, etc.)	1	Black, White,	
200	ral', o	by	3 ☐ Widowed 4 ∑Divorced	If Yes, (Year or	Give		1□Yes 2√□N	lo Specify	/ :			Specity: WH	IITE
215-0036	n 72 ho natur	Completed	15. Decedent's E (Specify only highest gr		d)	(Give	dent's Usual Occ kind of work do DO NOT use ret	ne during mo	st of worki	ing	16b. Kir	nd of Business/In	idustry
-	within ene. than	ошо	Elementary/Secondary (0-12)	College	(1-4or 5+)	me.	CLE:	,			WIC	COMICO C	OUNTY
ק ק	e filed Il Hygi other	Be C	17. Father's Name (First, Middle, Last)					ner's Name	(First, Middle,			
Maryland 2	should be and Mental marked o	ToE	AMOS COX						ET RE				
Mar	2 6 5 6		19a. Informant's Name/Relationship (-	Town, State, Zij	
	s 1 and of Health Item 27 other to	1	CINDY BOUNDS - DA 20a. Method of Disposition	UGHIEK	20b. F		NINGSIU esition (Name of matory or other p		40	-		ARYLAND cation - City or To	
Ē	00 0 400 20		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		III State		EMETERY		07-05	5-2005 S	ILOA	AM, MARY	LAND
Baltimore,	permit. Pag Depertment Importent: I any injury o		21. Signature of Funeral Service Lice	nsee	hur							HOME,	INC. ND 21804
			23a. Part1. Enter the disease, or come shock, or heart failure. List only	plications tha	caused the deat							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	· K	len o	can	cen						Onset and Death
	/Medical Examiner		resulting in death)	Due 1	to (or as y consec	quence of):						1611	
	61.3	ē	Sequentially list conditions, if any, leading to immediate	b. Due t	to (or as a consec	quence of):							
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease of injury) that initiated events	c									
60,	death certificate be executed e ettending physicien and of for use as the burial-transit	EX EX	resulting in death) Last	Due t	to (or as a consec	quence of):							
68760	ficate I physi	edical		_ d									
Box	eath certific ettending p I for use as	In/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna	ancy	∃Ectopic pregna	ncv			2	3d. Date of deliv	*
о. В	at the deat by the ett tached for	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑No - 9 □ Unknown		gnant at time of o		Other (specify,					Month	Day Year
s, o	s that ined by e deta	by Ph	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying cause	given in Parl	ıl.	23e. Did to	bacco u	se contribute to t	the cause of death?
ğ	w requires been sign should be				<u> </u>	·				104	es 2[No 3 ☐ Pro	bably 4 Dunknown
Vital Record	The la ate has page 2	Completed								24a. Was a autops perfor 1 Yes	sv	24b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	l la anitale				Oth on	1	(Check only or			
	this al di	To.	1 Yes 2 → No 27. Manner of Death		□Inpatient 2□ te of Injury	ER/Outpatier 28b. Time o	IT 3LI DOA		The state of the s	me 5 Resid		Other (Speci	fy)
0	nding fith. : After s funera	ation	1 GNatural 5 ☐ Pending 2 ☐ Accident investigation	(M	onth, Day Year)	Injury		njury at Vork? □ Yes 2[, ,		
Division of	or Attendate after death Director: A in by the f	ertification:	3 Suicide 6 □ Could not be determined	280. Pla	ice of Injury - At hilding, etc. (Speci	ome, farm, st	reet, factory, offi	се		28f. Location (S City or Tow			al Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifying P (Check only one)	miner: On the	the best of my know basis of examina anner stated.								
	To the within To the comple	Me	29b. Signature and title of certifier			WW WWW.	29c. Lice	ense numbe	T	2	29d. Date	signed (Month,	Day, Year)
}	3		12/10	H	-		0	293	4)	6	3/3	0/05.	
	100		30. Name and address of person who WILLIAM ROBINS,	M.D.	200 CIVI	C AVE.	SALIS	BURY,	MD. 2	21804			
	Sta Regist	ate rar	31. Date filed (Month, Pay Year) 1	2005 32	. Redistrar's Sign	ature	book						

			For State Registrar	State	of Marylan		artmen			and M		giene Reg. No. 2	0.0.5	23438
	Physici	an	1. Decedent's Name (First, Middle SARAH LOU		ICE						2. Date of Dea Month	Day	Year	5. Time of Death U
	/Medio Examin		4a. Facility Name (If not institution				4b. City,	Town, or	Location of	of Death	07		inty of Death	
	Examin	er	Washington Cour	_			,		ersto			1	Washin	gton
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.		If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birth	place (State or Foreign ntry)
L	Director		220-09-7297 Usuel Residence of Decedent		89	Yrs.					Oct. 5	, 1915	Ma	ryland
	yland now		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d, Inside City Limits
	e Mar	ctor	Maryland Wasi	nington	H	agerst	own							1 XYes 2 No
	vith th	Funerai Director	10e. Street and Number				10f. Zip		7.0			_	of What Cou	ntry?
	s 23e	erai	1183 Luther Dr:		cedent Ever in U	S 13 1	Was Decer		740	gin? (Sp	acify Yes or No-		SA Race - Ameri	can Indian
' 0	fter d	Fun	1 ☐ Never Married 2 ☐ Marr	Armed F	orces? 2 K]No						ecify Yes or No- Rican, etc.)	E	Black, White,	etc.
21215-0036	72 hours after deeth with the Maryland "natural", or items 23a or 28a-f show oftest Examinan mat be notilied at	by	3 X Widowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		1□Yes	2 X] No	Specify:			Spe	ecify: whi	lte
5-0	72 h	etec	15. Decedent (Specify only highes	's Education it grade completed)	16a. Dece (Give	kind of wor	rk done d	during most	t of work	ing	16b. Kind o	f Business/Ir	ndustry
121		Completed	Elementary/Secondary (0-12)	_	(1-4or 5+) ()		DO NOT us etary	se retired)			hosp	ital	
d 2	a filed within Hygiene. othar than	Be Co	17. Father's Name (First, Middle,						18. Mothe	er's Name	e (First, Middle,			
ılan		To B	William Smith					ĺ	Sus	an E	Baker			
Maryland	an an		19a. Informant's Name/Relations				-				al Route Numbe	-		
	s 1 and 2 of Heelth item 27 other tra		Audrey Hamm - o	laughter	20h F						erstown		y Land on - City or T	
Baltimore,	Pages nent of I ant: if ite ury or of		1 X Burial 2 ☐ Cremation		1 State	Place of Disponentery, cremetery, cremetery				7/6				, Maryland
Itin	permit. Pages Department of Importent: If I any Injury or one	1	4 □ Donation 5 □ Other (S_i21. Signature of Funeral Service		Tit.		2. Name an			_	MINNICH			
B	permit. Departr Importe any inju	. 6	Scott	MM	mail	4	15 E.	Wil	son B		, Hager			
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on a. AC	caused the deat each line.	ESPINA					or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Examiner	_	Sequentially list conditions,	b	ASOVAL P		ינדטפו ?	E						
	bed nsit	niner	tany, leading to immediate cause. Enter Underlying Cause (Disease or injury		o (or as a conseq PRAESO/	,	A1. H	FRN	J) A					
Ć,	be exacuted sician and burial-transit	Examin	that initiated events resulting in death) Last	U	(or as a conseq									
8760,	cate be physicia the bur	icai		d										
.O. Box 6	The law requires that the death certificate be exacuted ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregna birth 2 Feta gnant at time of d	al death 3	Ectopic pr Other (sp					23d.	Date of deliv Month	ery Day Year
Records, P	quires that n signed t uld be dett	by	Part II. Other significant condition DEMENTIA	ens contributing to	death but not res	ulting in the u	nderlying c	ause giv	en in Part I.	•				he cause of death?
CO	aw requir is been s 2 should	plet	HYPEKTENS	100							24a. Was		b. Were auto	opsy findings available ompletion of cause of
I Re		Completed									perfo	rmed?	death?	2 No
Vital	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	1				0.11		of Death	(Check only o	ne)		
of	Phys this al dii	To I	1 Yes 2 No			ER/Outpatier		_	4 🗀 190		me 5 ☐ Resid 28d. Describe h			fy)
		tion	1 Natural 5 Pendin 2 Accident investig	9	of Injury oth, Day Year)	Injury	M	8c. Injun Worl 1 □	k? Yes 2.∏I		280. 00301001	iow injury oc	Culled	
Division	i or Attendi efter death. Diractor: A d in by the fu	Certification;	3 Suicide 6 Could a determine	not be 28e. Plac	e of Injury - At hiding, etc. (Specia	ome, farm, sti fy)	reet, factory	, office			28f. Location (S City or Tow		ımber or Run	al Route Number,
	To the Hospital or Attending within 24 hours effer death. To the Funerel Director: After completely filled in by the fune	edicai C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To th Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	nd place, ath occurr	and due to the deed at the time, d	cause(s) and date and plac	manner as s ce, and due t	stated. o the cause(s)
	To th Within To th	Me	29b. Signature and title of certifie				290		e number				ned (Month,	
١,	12		▶ Mashan		A-14-765				2567			07	-03-0	5-
	5		30. Name and address of person WASHINGTON COUL								,	CRIT	wn "	no 21740
	Sta	te	31. Date filed (Month, Day, Year)	32.4	agistrar's Signa	ature		V (F	2	, , , , ,	1 / "			-1140
	Registr		JUL 0 3	2005	The same	B. 6.	etil							

			State	State of Maryland	-				000		~ ! ~ ~
	_		Registrar 1. Decedent's Name (First, Middle, Last)	<u> </u>	Cel	tificate of l	Death	2. Date of Deat	eg. Nyd.	5 2	Time of Death
п	Physicia		Laura	Reynolds				Month 6-	Day 79	Year 2005	0145 AM
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County		
		٧.	University of	Maryland		T3914	more				
	. Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	-	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Country)	(State or Foreign
	Director		ZZO 96 5602 10 Usual Residence of Decedent	30	Yrs.			4/24	25	Mar	yland
	yland iow		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. l	nside City Limits
	e-f st	io	Maryland Calve	rt	Рс	rt Repu	blic			1	I□Yes 2∏No
	72 hours after death with the Maryland neturel', or items 23e or 28e-f show dical Examiner must be notified at	Directo	10e. Street and Number			10f. Zip Code	00676	1	0g. Citizen of V		
	s 23e	srai	1625 Gray		10.1	M - 5	20676		US		
	ter de	Funeral	11. Marital Status 1 Never Married 2 ☑ Married 1	 Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No 	. 13. 1	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)		e - American Ir k, White, etc.	ndian,
036	urs at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2∭ No	Specify:		Specify	Black	C
21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usual Occupa	ation during most of work	sina	16b. Kind of Bu		
121	within ene. then "	ld m	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done o DO NOT use retired Housewi			Own H	o m o	
75 17	filed v Hygie other t		17. Father's Name (First, Middle, Last)			Housewi	18. Mother's Nam	e (First Middle)			
an	ld be ental ked o ic eve	To Be	James Essie Pa	arker				Jane Gr		,	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other then "neturel", or items 23e or 28e-f show or other treumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street				State, Zip Cod	le)
	and 2 saith a n 27 is		Ernest Reynolds,	Husband	1625	Grays	Road,Po	rt Repu	blic.	MD 20	676
Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	COI	netery, crer	sition (Name of natory or other place	e)		20c. Location -	-	
tim	Pages tment of I tent: If its ijury or o		'4 Donation 5 ☐ Other (Specify)	Chel		am Vet.		05/05	Chelte	enham,	MD
Bai	permit. Page Department Importent: If any injury or once.		21. Signature of Funeral Service License	well		Name and Address 51 Dare	Ų	ewell F Rd.Pri	unera: nce Fi	l Home red.,M	D 20678
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Inte	proximate erval Between
	Prysician		Immediate Cause (Final disease or condition resulting in death)	Mul	tid	e Orgo	in to	luve		Ons	set and Death
	/Medical Examiner		Toolaning in doubly	Due to (or as a conseque	ence of):	J					
		- le	Sequentially list conditions, it any, learning to introduce cause. Enter Underlying Cause (Disease or injury	Due to (or as a consult)	ence of):	1 .		1 ,		-	
	outed id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Inte	de	t och	spedic	hardw	ave		
Ő,	sician and burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):						
8760,	cate be er ohysician the buria	dlcal	ď								
9	death certificate be executed e attending physician and id for use as the burial-transi	Physiclan/Med	IF FEMALE:	Bc. If yes, outcome of pregnan	cv	77			224 Day		
Вох	death atter d for u	clar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)			Mo	te of delivery nth Day	Year
o.	that the d ed by the detached	hysi	9 Unknown	9□ Unknown						,	
s, P	requires that the een signed by th hould be detache	ру Р	Part II. Other significant conditions con	ributing to death but not resul	ting in the u	nderlying cause give	en in Part I.	23e. Did tol	oacco use cont	ribute to the ca	use of death?
ord	w require been si should b							1 □ Ye	es 2□No	3 Probably	4 ∰Unknown
ecc	aw Is b	ompleted						24a. Was a autops	y r	prior to complet	findings available tion of cause of
of Vital Record	Th ate pag	Con						1 Yes		death?	No
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		Oth		th (Check only on			
	Phys r this aral dii	1: To	1 Yes 2 No 127. Manner of Death	28a. Date of Injury	R/Outpatier 28b. Time of		er: 4 ☐ Nursing Ho	ome 5 Reside 28d. Describe ho			
ion	Attending It death. ector: After by the fune	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Worl	k? Yes 2□No				
Division	tel or Attending P s after death. el Director: After ti ed in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (SI City or Town	reet and Numb	er or Rural Ro	ute Number,
ā	itel or irs afte rel Dir led in l	Cer		Bending, etc. (opeciny)				0.0, 0, 70.0	-, 5.12.0)		
	Hospitel or 24 hours afte Funerel Dire etely filled in b	edical	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Exemin	ician: To the best of my know er: On the basis of examination and manner stated.	rledge, deatl on and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and ma ate and place,	inner as stated and due to the	cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. License	e number	2	9d. Date signe	d (Month, Day,	Year)
)	, (I fam & Mal	- MD		104412	6435101)	-pr-	1/25/0	5 /	
	4		30. Name and address of person who con		23а) (Туре,	Print)			1 1		
			JASON Moche	38 J. Phill.	St 7	Print)	34/pmore	-, MO	11201		
ž.	Sta Registr		31. Date filed (Month, Day, Year) JUN 3	2005 Marin	, K	Sperke	•				

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) Dorothy DeAtley Sayre 2. Date of Death Month June 29, 2005 1:00 P M 4a. Facility Name (If not institution, give street and number) 9750 Hedin Drive 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 2 Months			•	1 - For State Registrar	1 10400	-	f Marylar	nd / Depa		of H	lealth a		-	gien	_		34	l. n
Directory Description Familiar Fa					irst, Middle, La	st)								ath		3.	Time of	f Death
Securition Security Number Control processor Security Number Control processor Security Number Silver Spring Number Security Number Secu				Dorothy	De	eAtley		Sayre)								00	рм
Dischool Dischool					_		mber)		4b. City,	rown, or	Location o	of Death		4	c. County of	Death		
The common service of the common service o																		
Uses Templated Community Uses Templated Community Uses												Min.						or Foreign
Privacian Priv	_						02						Aug. Z	4, 1	922	Alaban	na	
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Privician (Alectical Examiner) 23. Part : Finer the disease, of complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arrest, shock, or heart failure. List (my) one cause or each line. Aspiration or each of each such line and the cause of the death. Do not enter the mode of ying, such as cardiac or respiratory arrest, shock, or heart failure. List (my) one cause or each line. Aspiration or each of each of heart significant conditions contribute to the cause of death. Do not enter the mode of ying, such as cardiac or respiratory arrest, shock, or heart failure. List (my) one cause or each line. Aspiration or line and beath of the cause of death. Do not enter the mode of ying, such as cardiac or respiratory arrest, shock, or heart failure. List (my) one cause or each line. Aspiration or line and beath. Do not enter the mode of ying, such as cardiac or respiratory arrest, shock, or heart failure. List (my) one cause or each list (my) one cause or each list. Aspiration or list (my) or cause or each list. Aspiration or list (my) or cause or each list. Aspiration or list (my) or cause or each list. Aspiration or list (my) or cause or each list. Aspiration or list (my) or cause or each list. Aspiration or list (my) or cause or each list. Aspiration or list (my) or cause or each list. Aspiration or list (my) or cause or each list. Aspiration or list (my) or cause or each list. Aspiration or list. Aspirati	5-0	72 hc	etec					16a. Dece (Give	dent's Usua kind of wor	l Occupa	ation during most	of worki	ng	16b. I	Kind of Busir	ness/Industr	у	
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9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 1 Yes 2 No 2 Yes 2	9 ×	ding p	/Med			23c If yes out	tcome of pregn	ancy							001 0-1-	1 4-11 -	-	
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1 Natural 2 Accident 3 Suicide 4 Homicide See Place of Injury - At home, farm, street, lactory, office 28l. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	of \	Phys this al di	-			1 1												
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State 31. Date filed (Month, Day, Year) 33 Registrar's Signature		17							Print)				ver Spr	ing	, MD 2	20902		
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			For State Registrar	State of M	aryland	-	artment of			-	giene		23441	
	Physicia		Decedent's Name (First, Middle, La	st)		SCOT	r			2. Date of De Month	-	Yea	3 49 0 10 1	
	/Medic Examin		4a/Facility Name (If not institution, give			1	4b. City, Town,	or Locatio	n of Death	·		County of De		
			Peninsula Regio	nal Medi	ical (enter	ک دراور اوران	alst	Kery		1	VICON		
	Funeral Director		5. Social Security Number 220-28-2549 Usual Residence of Decedent	Sex 7. AG	ge (<i>in yr</i> s. <i>i</i> e 76	Yrs.	If Under 1 Yea Months Days		er 24 Ars. Min.	8. Date of Bir (Month, Da Oct. 2,	th ly, Year) 192	9. 8 So	inthplace (State or Fore Country) uth Carolin	•
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Lim	nits
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	or 28	Directo	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What	Country?	
	sath v	erai	26606 Walnut Tree	Road 12. Was Decedent	Ever in II 9	2 12	2182		Origina /Co.	offic Von ar No		JSA	nerican Indian.	
920	hin 72 hours after death with the Maryland B. "natural", or Itams 23a or 28a-f show M. dical Examiner must be natified a	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2XX If Yes, Give Year or Dates:	?		Was Decedent of fYes, specify Cu 1 ☐ Yes 2 💆 No			Rican, etc.)	-	Black, Wh		
	S 24	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)	(Give	lent's Usual Occi kind of work don DO NOT use retir	e during m	ost of work	ing	16b. Ki	nd of Busines		
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anc	bed all all all all all all all all all al) Be	Henry)	Drico	C.				(First, Middle,	, Maiden			
Maryland	S D E E	오	19a. Informant's Name/Relationship	Type, Print)	Price		ng Address (Stree		innie aber or Rura	al Route Numbe	er, City o	Will: r Town, State		-
	nd 2 lith a 27 Is r tra		Isom Scott/husband	i		26606	Walnut	Tree	Road	- Eder	n, M	aryland	21822	
altimore,	0 0		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □	Removal from State		ace of Dispo	sition (Name of natory or other pi			Date			or Town, State	
<u>H</u>	. Pages Iment of tant: If it jury or o		* 4 □ Donation 5 □ Other (Speci	(y)		nghill	Mem. Go	ins	07/02	/2005	Hebi	con. Ma	aryland	
Bal	permit. Pag Department Important: I any injury o		21. Signature / Funeral Service Lice	3. Juli	ley		. Name and Add				Roa	ad – Sa	lisbury, Md 21801	l
	-		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each li	d the death ine.	. Do not ent	er the mode of dy	ring, such	as cardiac o	or respiratory a	rrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. A-	SCV	19							Onset and Death	
	/Medical Examiner		resulting in dealth)	Due to (or as	a consequ	ience of):								
	4	er	Sequentially list conditions,	b. Due to for as	a consequ	ence of								
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	, ρ	VI	>								
ó	s be executed sician and burial-transit		resulting in death) Last	Due to (or as	_									
8760	ate by	dical		_ d	DV	1					_	_	 	
9 ×	eath certific attending pl	/Med	IF FEMALE:	23c. If yes, outcome	of prognar	2014		- 77						
Box	eath c atten	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pregnan Other (specify)	су			,	23d. Date of d Month	elive <i>r</i> y Day Year	
o.	that the de ned by the a detached	hysi	9 Unknown	9□ Unknown									-	
Vital Records, P.	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions	contributing to death t	out not resu	Iting in the u	nderlying cause g	iven in Pai	t I.		obacco u Yes 2{	_	to the cause of death? Probably 4 Unknow	
900	fawre as bed 2 sho	ompieted								24a. Was autor			autopsy findings availal completion of cause of	
		Сош								perfo	rmed? 2 No	death?	' <u> </u>	
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital: 🎺			0	thor		(Check only o				
of	Phys rthis ral dii	1: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ıry	ER/Outpatier 28b. Time of	T JU DON			ne 5 Resident			ecify)	-
ion	Attending In death. actor: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	W	ork?]Yes 2				,		
Division	I or Attendii after death. Diractor: A I in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At hor tc. (Specify		eet, factory, office)		28f. Location (: City or Tox	Street an	d Number or I	Rural Route Number,	
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	To the Hospital or A within 24 hours after To the Funaral Diraccompletely filled in by	ledical	one)	nysician: To the best miner: On the basis o and manner st										
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,	B		'(W O	HO	105	74	10	p	20%	105	
	50		30. Name and address of person who	completed cause of o	death (Item	23a) (Type,	Print)	C'.	1.oh	(31 00	h .	21801	-5492	
	Sta	ite ar	31. Date filed (Month, Day, Year)	2005 32. Resisti	rar's Signati	ure	Print) Yro(1 54	<u>Sa</u>	115 00	7, 11	٠ . صو		J 7 /3	

Rosa Scott 320-38-2549

			1 - For State Registrar	State of Ma		artment of rtificate of		nd Mental Hy	giene	23442
t	Physici		Decedent's Name (First, Middle, Last) Anna	К.	S	zwed		2. Date of De. Month June 29,	ath Day Year	3. Time of Death 4:05 A
: *	/Medic Examin		4a. Facility Name (If not institution, give Waldorf Healthcare Cer	street and number)		4b. City, Town, Waldorf	or Location of		4c. County of Dea	
	Funeral Director		377 34 7034	7. Ag	e (In yrs. last birthday 97 Yrs.	Months Day		8. Date of Bird (Month, Date)	1907 Penns	rthplace (State or Foreign Journy) SYLVania
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Charles		10c. City, Town or L LaPlata	ocation				10d. Inside City Limits 1 ☐ Yes X2√√No
	with the 3s or 28s	Il Director	10e. Street and Number 9247 Mimosa Drive			10f. Zip Code	646		10g. Citizen of What C	country?
036	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other than "natural", or liems 23s or 28s-f show event, I a Mcdical Examiner master mallied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ∰Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2001 If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu	ban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	Black, Wh	
Maryland 21215-0036	d within 72 ho giene. ir than "natur II.e Mcdical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> College (1-4or 5	(Giv life.	edent's Usual Occ e kind of work don DO NOT use retii omemaker	e during most	of working	16b. Kind of Busines:	s/Industry
/land	uld be file Mental Hyg Irked othe Itic event,	To Be C	17. Father's Name (First, Middle, Last) Thomas Oshnock					's Name <i>(First, Middl</i> e, erine Kasuba	Maiden Sumame)	
a)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If time 27 Is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Ins Marylan Examination ust two multiples at once.		19a. Informant's Name/Relationship (T) Cheryl A. Shifflett/Gra 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)	ndaughter	9247	Mimosa Dr position (Name of amatory or other p	ive LaPla	r or Rural Route Number ata Maryland Date 1y 1, 2005	er, City or Town, State, 20646 20c. Location - City o Suitland, M	r Town, State
Baltil	permit. F Departme Importar any injur		21. Signatur Funeral Sorgice Licens	elas 1	1	2. Name and Add	ress of Facility	-	las Funeral H	
	/Medical Examiner	dicai Examiner	23a. Part. Enter the disease, or companion, or hock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):				ilest,	Approximate Interval Batween Onset and Death
	The law requires that the death certifica sie has been signed by the attending phy page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2XXXo 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnan	су		23d. Date of de Month	elivery Day Year
ds, P.	uires that I signed by Id be deta	d by Ph	Part II. Other significant conditions co		ut not resulting in the	underlying cause o	jiven in Part I.		obacco use contribute	to the cause of death?
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Division of	Attending PI r death. ector: After th by the funeral		27. Manner of Death 1 XX Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury	W	uryat ork? □Yes 2□N		how injury occurred	
	in Site	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, offic	9	28f. Location (S City or Tox	Street and Number or F wn, State)	Rural Route Number,
	e Hospitel 24 hours a e Funerel I letely filled	edicai	29a. Certifier 1XXCertifying Phy (Check only one) 2 Medical Exam	sician: To the best ner: On the basis o and manner st	f examination and/or i	ith occurred at the nvestigation, in my	time, date and opinion, deatl	f place, and due to the hoccurred at the time,	cause(s) and manner a date and place, and du	is stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of pertifier				nse number 12509		29d. Date signed (Mon	4
CA	2(3)		30. Name and address of person who come Meindert Smith Meindert Sm		leath (Item 23a) (Type 0 01d Line	,	#100	Waldorf, Ma	aryland 206	
	Sta Regist		31. Date filed (Month, Day, Year) JUN 3 0 2005	2. Registr	rar's Signature	all)				

State of Maryland / Department of Health and Mental Hygiene

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	aryland show	2	10a. State 10b. County		10c. City,	Town or Location					10	Od. Inside City Limits
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0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Items 23a or 28a-f show any follury or other traumatic event, the Marical Evarinet must be notified at once.	by Funeral Director	11. Marital Status 1☐ Never Married 2☐ Married	12. Was Decedent Armed Forces? 1 ∑ Yes 2 ☐ If Yes, Give	•	-	ecedent of specify Cul	Hispanic Origin? (ban, Mexican, Pue) Specify:	(Specify Yes or Nerto Rican, etc.)		ce - America ck, White, e	
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ar _y	shou mar mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing Addr	ess (Stree	at and Number or F	Rural Route Num			Code)
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			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused	the death.	Do not enter the n	node of dyi	ing, such as cardia	ac or respiratory	arrest,		Approximate
\	Physician		orrown or mount reliate. Else on	y one cause on each in	ne.						1	Interval Between Onset and Death
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	s after d	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubuilding, etc	iry - At hom :. (Specify)	e, farm, street, fact	ory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural i	Route Number,
;	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai (29a. Certifier 11 Certifying Pl	nysicien: To the best of	examination	edge, death occurre n and/or investigation	d at the tir	me, date and place	e, and due to the urred at the time,	cause(s) and ma date and place.	inner as stat	led. he cause(s)
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3	S/IVA		Noncock	3000	9		100	35525		July	1,20	DE 5
	1		30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type, Print) Pace				0		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** James Michael Smith Julv 2005 4:15 P 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 78 LaVale Boulevard LaVale Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1∭M 2□F Yrs. Director 215-42-2691 60 05/05/1945 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f show the Medical Examinar must be rediffed at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
sint: If lean 27 Is marked other than "natural", or Items 23stry or other traumatic event. It will be a sur. 78 LaVale Boulevard 21502 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1)X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced White Vietnam Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Svlvester Joseph Smith Eula Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan_S. Smith / wife 78 LaVale Boulevard, LaVale, Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. ' 4 ☐ Donation /5 ☐ Pther (Specify) 07/08/2005 Cumberland Crematory Cumberland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CELL CANCER OF LUNG SMALL **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ✓ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the tuneral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5XXResidence 6 Other (Specify) 1 ☐ Yes 2 Z No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1 ZNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide W Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) IVA D0023371 July 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nls Qamar U. Zaman, M.D., 625 Kent Avenue, Cumberland, Maryland 21502 31. Date filed (Month Day, Year) 2005 32. Engistrar's Signature State Registrar

			1 - For State Registrar	State of Ma	aryland / De	partment of He ertificate of D	ealth and I	Mental Hy	giene Reg. No		231.1.5
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	3			au		DO 059	157		July	5, 2005	5
	YRS		30. Name and address of person who Mashukur Khan, Hu	Indman Area	a Health (Center, Che	stnut S	treet. H	undma	ın. PA	15545
	Sta Registr	te ar	31. Dale filed (Month, Day, Year)	5 Registra	r's Signature	arte					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. NO 0 5 Physician / Medical Examiner 1. Decedent's Name (First, Middle, Last) Virginia C. Shaver 4a. Facility Name (If not institution, give street and number) 1. Decedent's Name (First, Middle, Last) Virginia C. Shaver 4a. Facility Name (If not institution, give street and number) 1. Decedent's Name (First, Middle, Last) Virginia C. Shaver 4b. City, Town, or Location of Death Parkton Baltimo: S. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. July 19, 1925 Ma	
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Physician /Medical Examiner **Virginia C. Shaver** 4a. Facility Name (If not institution, give street and number) **1212 Rayville Road** **Parkton** **July 8, 2005** 4c. County of Death **Parkton** **Baltimos: **Director** **Director** **Parkton** **Social Security Number** 5. Social Security Number** 5. Social Security Number** 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8. Date of Birth (Mon	1
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Director 5/9-28-8521 12 79 11s. July 19, 1925 Ma	nplace (State or Foreign
Usual Residence of Decedent	rýland
	10d. Inside City Limits
MD Baltimore Parkton	1 ☐ Yes 2X No
BAICTINGLE FAIRCOIL 106. Street and Number 106. Zip Code 10g. Citizen of What Cot	untry?
1212 Rayville Road 21120 U.S.A.	
To a. State 10b. County 10c. City, Town or Location 10d. Zip Code 10d. Citizen of What Code 21120 10d. Street and Number 1212 Rayville Road 21120 10d. Street and Number 1212 Rayville Road 21120 10d. Street and Number 1212 Rayville Road 11d. Marital Status 11d. Marital Status 11d. Marital Status 11d. Marital Status 11d. Marital Status 11d. Never Married 2d. Maried 11d. Yes 2 No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11d. Was Decedent's Education 11d. Specify: Will yes, Give Yes aron Dates: 15d. Decedent's Education 16d. Decedent's Usual Occupation (Give kind of work done during most of working 16d. Kind of Business/I	
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19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z	
Diane V. Thompson/Daughter 1212 Rayville Rd., Parkton, MD 21	
20a. Method of Disposition State	
Methodist Cemetery 2005 Parkton, 2005 Parkton, 21 Stepature of Funeral Secret Licensee 22 Name and Address of Facility J.J. Hartenstein Mor	
m and Address of Facility J.J. Hartenstein Mor.	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician Immediate Cause (Final disease or condition a Metastatic Colon Caravoma	onset and Death
/Medical resulting in death) Due to (or as a consequence of):	6413
Examiner Sequentially list conditions, b.	
Sequentially list conditions. Sequentially list conditions. Lary Jacoby to I.n. edita cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Co. Due to (or as a consequence of): Due to (or as a consequence of):	
that initiated events c. Due to (or as a consequence of):	
9 e giging and and a second a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a second and a second and a second a second and a second a second a second a second and a second and a second and a second and a	
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F FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 1 Live birth 2 Fedadath 1 December 1 December 1 1 December 1 December 1 1 December 1 December 1 1	
· O o O I I I Yes 200No	Day Year
	the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 yes 22 No 3 Pro 24a. Was an autopsy performed to death? 1 yes 22 No 1 Pro 25b. Were autopsy performed to death? 1 yes 22 No 1 Pro 26c. The state of the	bably 4 Unknown
Of MORESIVE dementia 24a. Was an 24b. Were au	topsy findings available
Extensive Christovascular disease 1 yes 2 kno 3 pro 24b. Were au prior to o death 1 yes 2 kno 3 pro 24b. Were au prior to o death 1 yes 2 kno 3 pro 1 yes 2 kno 3 pro 24b. Were au prior to o death 1 yes 2 kno 3 pro 1 yes 2 kno 3 pro 1 yes 2 kno 3 pro 1 yes 2 kno 3 pro 24b. Were au prior to o death 1 yes 2 kno 3 pro	ompletion of cause of
25. Was case referred to medical examiner? Hospital: Hospital: 4 Planting of Cher. 4 Number No. 2 Planting of Cher. 4 Planti	2.PCNo
	rify)
27. Manner of Death 28a. Date of Injury Work? 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work? 1 Natural 5 Pending Injury M 1 Natural 5 Pending	
Natural 5 Pending (Month, Day Year) Injury Work? 1 Yes 2 No Sylicide 4 Sylicide Sylicide 4 Sylicide Sy	
28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	ral Route Number,
29a. Certifier 12 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the causes, and manner as (Check only 2) Medical Examiner: On the basis of examination and/or investigation in my pointon, death occurred at the time, date and place, and due	stated
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one)	to the cause(s)
	, Day, Year)
Natural Substitute Substi	
29c. License number 29d. Date signed (Moeth	05
29b. Signature and title of cerefler 29c. License number 29d. Date signed (Month 29d. Date signed (Month 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	08
JULIA COUNTY DASSAY HILL 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) L RUTH KONTO M. D. 6569 N. Charles St. Bautmore Md	21204
29b. Signature and title of ceptier 29c. License number 29d. Date signed (Moeth 29d. Date signed (Moeth 29d. Date signed (Moeth 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) 32. Piglstrar's Signature 111 1 6 2005	21204

ORIGINAL

05-4203 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNKNOWN
Manaces Cristobal For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Manaces Cristobal Sanchez 2005 20, 1029 A M JUNE /Medical 4a. Facility Name, (If not institution, give street and number) 8228 14th AVENUE **Examiner** 4b. City, Town, or Location of Death COLLAGE PARK 4c. County of Death
PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/31/87 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 17 **Director** Unknown Guatemula Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28e-f show Medical Examinar must be notified at Silver Spring Montgomery Md Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1614 Neely Rd 20903 Guatemula Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1X Yes 2□ No Be Completed by Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry At Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NA E) a 6th 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file
Department of Health and Mental Hy
Importent: If Item 27 Is marked oth
any injury op other treumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Jose Angel Cristobal Isabel Sanchez Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isaias Sanchez Uncle 1614 Neely Road Silver Spring, Md 20903 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/10/05 CaTastrofica DE `4 Donation 5 Dother (Specify) Family Cemetery Ostuncalco 22. Name and Address of Facility Snead funeral Home 21. Signature of Funeral Service Licensee 5732 Georgia Ave NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Stab Wounds Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dus to (or as a consequence of). To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No autopsy performed? 1 Yes 2 □ No 25. Was case referred to medical 26. Place of Death Check on one examiner' Other: 4 Nursing Home 5 Residence 6 Nother (Specify) AT SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Found 10:15/4 1 Natural 5 Pending Found Subject Stabbed 1 ☐ Yes 2 🗖 No 2 Accident investigation 6/20/05 3 ☐ Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Parkura 16+ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4238 14Th AC

Division of Vital

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of pe

31. Date filed (Month, Day, Year)

JUN 3 0

M. D. 32/Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

111 Penn Street

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

Prince Georges

JUNE

Couvit

21, 2005

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

Year

			For State	State of M	laryland		artment of Hetificate of L		nd Mental		2005	201	1.0	
			Registrar 1. Decedent's Name (First, Middle, La	st)			incate of L	Jeaur	2. Date of	f Death		3. Time o	f Death	
	Physici /Medic		MIRI		SCO	TT					^{Day} 2005 Year	2:15	Ам	
	Examin	er	4a. Facility Name (If not institution, giv 3146 GRACEFIELD				4b. City, Town, or CTT.VI	Location of ER SPI			4c. County of Death PRINCE GE		!	
	Funeral		5. Social Security Number 6. S	6ex 7. A	ge (In yrs. Ia	ast birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8 Date of			place (State untry)		
	Director		578-22-2821 Usual Residence of Decedent	□ M 2∏ F	81	Yrs.	Months Days	110013	JAN :	, 19	24 MARY	LAND		
	yland how		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside C	ity Limits	
	Ba-fs	ector	MARYLAND MONTGOM	ERY	PR	INCE (GEORGE'S			-1			2 □ No	
	with th	Funeral Director	10e. Street and Number 3146 GRACEFIELD RO	DAD #204F	rR		10f. Zip Code 20904				Citizen of What Cou ITED STAT	•		
	death	nera	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S		Vas Decedent of His f Yes, specify Cubar	spanic Origi	in? (Specify Yes of	r No-	14. Race - Amer Black, White	ican Indian,		
36	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show is Medical Evartiner must be rodified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1X Yes 2 ☐ If Yes, Give Year or Dates:	No			Specify:	T don't i hour, ord	,	Specify:			
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Maryland	2 should be and Mental is marked craumatic evo	To B	ABRAHAM	BLOC	CK			N	MINNIE	INNIE SCHERR				
Mar	12 sho h and 7 is mu traum		19a. Informant's Name/Relationship (g Address (Street a						01/	
	s 1 and f Healt item 2 gther		20a. Method of Disposition	NIECE	20b. Pl	ace of Dispo	WHITLEY PA sition (Name of natory or other place		Date Date		Location - City or T		014	
<u>ii</u>	Parit and a second		1 ☐ Burial 2 🛣 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of the C	-1-2005	FAI	LS CHURC	H, VIR	GINIA						
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury of other traumatic events.		21. Signature of Funeral Service Lice	NERAL DIE PIKE, ROO	RECTION OF THE SECTIO	ON, INC.	0852							
ŀ			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the sath							Approximat Interval Bet	tween	
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8760,	cate be executed physician and the burial-transit	dicail	(d						_				
9	death certific attending pl		IF FEMALE:	23c. If yes, outcome	e of pregnar	ncv					23d. Date of deliv			
. Box	death e atten	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant a	2 🗌 Fetal	déath 3□	Ectopic pregnancy Other (specify)			_	Month	-	Year	
<u>Р</u>	that the de ed by the a detached t	Phys	9 🗆 Unknown	9□ Unknown		161 1- 16 -			070	Old tabass			1	
Records,	The law requires that the death certific ste has been signed by the attending p rage 2 should be detached for use as	by	Part II. Other significant conditions CHRONIC RENAL IN			iting in the ur	iderlying cause give	n in Part I.			o use contribute to			
Seco.	has be	Completed	CHRONIC CONGESTIV	VE CARDIOM	IYOPAT	HY				Mas an autopsy performed?	24b. Were aut	opsy findings ompletion of c	available ause of	
Vital F		e Col	25. Was case referred to medical					DE Diago	1 ☐ Y	es 2XI	death?	2□ No		
	dis y	To B	examiner? 1 ☐ Yes 2X No	Hospital: † Inpat	ient 2 🗆 E	R/Outpatien	t 3 DOA Othe				6 ☐Other (Speci	fy)		
on of	Jing Ph		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury	28c. Injury Work	?		ibe how in	jury occurred			
Division	Attending r death. actor: After by the fune	Certification;	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of In	jury - At hor	me, farm, str	eet, factory, office	′es 2∐N	28f. Locati	on (Street	and Number or Rur	al Route Num	ıber,	
Ö	Ital or irs afte ral Diri		4 - Homicide	building, e	tc. (Specily,					Tòwn, Sta				
	To tha Hospital or Attending F within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	edical	29a. Certifier 1	nysician: To the best miner: On the basis and manner s	of examinati	vledge, death on and/or inv	occurred at the time restigation, in my op	e, date and inion, death	place, and due to n occurred at the t	the cause me, date a	(s) and manner as and place, and due to	stated. to the cause(s	s)	
	To tha within 2 To the	×	29b. Signature and title of certifier	2 12	ת מ		29c. License				Date signed (Month,	**		
•	12		30. Name and address of person who	complete calls of	death (Item	23a) (Type	D0055	5522		JUN	NE 27, 20	05		
	•		ROBERT GERARD, M	D., 1500	FORES	T GLEN	ROAD, S	SILVER	SPRING,	MD	20910			
	Sta Registr	HILL O O COCT IN M. COMPLET												

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Ruth Kelly Strohmann June 27 2005 7:00pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carriage Hill Nursing Home Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 03/26/1906 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Washington, DC Yrs. **Director** 99 220-38-1642 Usual Residence of Decedent the Maryland : in tem 27 is marked other than "naturel", or items 23a or 28a-f show or gither treumatic event. It a Medical Exactions count be notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Chevy Chase 1 ☐ Yes 2X No Maryland Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filled within 72 hours after death with nent of Heelth and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Items 23a or: 4925 Chevy Chase Blvd. 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ X No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Kelly Julia Belle Lee ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a Important: if Item 27 is any injury of other tree once. William Strohmann (Son) 4925 Chevy Chase Blvd.-Chevy Chase, MD. 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Funeral June 28,2005 Alexandria,Virginia ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 2222 Wisconsin Ave., NW - Washington, DC 20007 a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hypertensive Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Res irator Failure that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Sepsis the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Pe 1 Yes 2 No 3 Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 Yes 2X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel or within 24 hours at To the Funerel D 29a. Certifier Example 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0047330 V. Mosunh June 28, 2005 O Swomes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Joseph, MD - 50 W. Edmonston Drive #207 - Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32 Registrar's Signature 2005 30 Registrar

DHMH 17 Rev 1/2001

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			1 - State Registrer			-	-	rtificate					g. No2	005	23450
	Physici	an	1. Decedent's Name (First, Mic	Idle, Lasi	t)							2. Date of Deat	h Day	Year	3. Time of Death
	/Medic			URI		TAK						JULY	4,	2005	
	Examin	er	4a. Facility Name (If not institut		street and n	u <i>mber)</i>		4b. City,		Location o	- 55			ounty of Dea	
	Funeral		8301 RIVER 5. Social Security Number	6. Se	×	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 2		8. Date of Birth (Month, Day,		MONTG 9. Bir	
L	Director		214-82-0889	1[⊒M 2]X]F	84	Yrs.	Months	Days	Hours	Min.	JULY 20	, 192	20	thplace (State or Foreign ountry) INDIA
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j	d sho	JO.		,	EDV				7D.4						1 Ves 2 □ No
	nours after death with the Maryland turel', or Items 23e or 28e-1 show at Examiner must be notified at	Director	MD • MON 10e. Street and Number	IGOM	EKI			3ETHES 10f. Zip				1	0g. Citize	n of What C	21
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36	s arre	by Fu	1 ☐ Never Married 2 ☐ M 3 ▼Widowed 4 ☐ Divorce	1	1 ☐ Yes If Yes, G Year or			1 □ Yes 2		Specify:		,	S	pecify:	
21215-0036	/ /2 hours affer death w "neturel", or Items 23e	edt	15. Deced	ent's Edi	ucation		16a. Dece	dent's Usua	d Occupa	ation			16b. Kind	of Business	. E. ASIAN
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Maryland	should nd Mer marke imetic	٦	MANG 19a. Informant's Name/Relatio			AL	19h Mailir	na Address	/Street a	and Number		ABI Route Number,	BHA City or T		Zin Codal
	nd 2 s lith ar 27 ls r treu		SHARAD TAK/		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							DA, MD.	-		<i>ΣΙρ</i> 000θ)
Baltimore,	ges 1 and 2 should it of Health and Mer if Item 27 Is marke or other treumetic		20a. Method of Disposition				Place of Dispo	sition (Nam	ne of						Town, State
<u><u>E</u></u>	Z = = Z		1 ☐ Burial 2 🛣 Crematio 1 ☐ Donation 5 ☐ Other	n 3 ∐1 (Specify,	Hemoval fron)	n State	IVERDA	,		1	7-4-	2005	RIVE	ERDALE	, MD.
3alt	permit. P Departme Importen eny injur once.		21. Signature of Funeral Servi	e Licens	see		- (C) C	Name and	d Addres	s of Facility	L HO	ME & CRI			
	20 = 0 a		23a. Part1. Enter the disease,	w	4 a T	MO1	547 5	801 C	LEVE:	LAND	AVE.	, RIVER	DALE,		20737
le.			shock, or heart failure. L Immediate Cause (Final	ist only o	ne cause on	each line.	DE 0 0	0. 0	7 - \	y, sour as c	Cardiac or	1950 - C	1		Approximate Interval Between Onset and Death
	nysician /Medical		disease or condition resulting in death)	-	a. H	o (or as a consec	mence of).	LIS	t pu	Ory	0	Trres	JT.	-	2 hours
E	Examiner		Conventinity list conditions		se.	vere	PW	Mo	Non	W.	+	1680	Sie		
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Į	Due to	(or as a consec	quence of):	001		1	-		-		10010
Ψ	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c. Due to	o (or as a consec	(774	60	10	80	212			
760,	ysician	ical E		l	_	7 (0. 45 4 0011000	(401100 01).								
	g phys			_	d										
Вох	death certifica e attending phy id for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant			utcome of pregna		Ectopic pre	ennancv				23d	. Date of de	
о: Ш	0 0 9	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			gnant at time of o		Other (spe						Month	Day Year
۵.	by ac	Phy	Part II. Dther significant cond	itions co	entributing to	death but not res	sulting in the u	nderlying ca	ause dive	on in Part I		23a. Did tob	acco use	contribute to	the cause of death?
ecords,	urres ma signed I	d by					3	,				1 □ Ye	1		obably 4 □Unknown
00	as been s 2 should	Completed										24a. Was ar	2	24b. Were at	utopsy findings available
œ j	9 - 6	шо										autops perform 1 Yes 2	red?,	death?	completion of cause of
Vital	certificate	Bec	25. Was case referred to medi examiner?	-						26. Place	of Death	(Check only one	-	1 4 100	
of \	tending rnysicien: feath. tor: After this certific the funeral director,	2	1 ☐ Yes 2 ☐ Mo				ER/Outpatier	-		4 LI NUI	7	e 5 Teside			cify)
	After une	tlon:	27. Manner of Death 1 □ Natural 5 □ Pen		28a. Date (Mo.	nth, Day Year)	28b. Time of Injury	M 28	Bc. Injury Work	at :? /es 2 □ N		8d. Describe ho	w injury o	ccurred	
Division	after death. Director: After	flca	3 ☐ Suicide 6 ☐ Cou	stigation Id not be rmined	28e. Plac	ce of Injury - At h ding, etc. (Specia	ome, farm, str			93 2 11	-	8f. Location (Str	eet and N	lumber or Ri	ural Route Number,
=	in the	Certification:	4 Homicide		build	ding, etc. (Special	fy)	. ,				City or Town	, State)		
	within 24 hours after or Au within 24 hours after or To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certification (Check only 2 Medic	ing Phy	sician: To th	ne best of my kno basis of examina	owledge, death	occurred a	at the time	e, date and	place, ar	nd due to the ca	use(s) and	d manner as	s stated.
	the F the F mplet	Medi	one) 29b. Signature and title of certi		and ma	nner stated.									•
	Z × C		290. Signature and title of certification	1-1	1-10	NAAN	9	296,	License	7-7	97	S- 25	Date s	igned (Mont	h, Day, Year) MAN 2005
7			30. Name and address of person	on who o	ompleted car	Ise of death (Iter	n 23a) (Tune	Print)	R.	HIRL	1 /	KHIA	VEX	7 70	
	\		19520 Do		25	Drive	Gres	ma	n.f.	oyon	1	MD. Z	20	371	1
	Sta		31. Date filed (Month, Day, Yes		4	Registrar's Signa	ature	1.			-				
	Registr	ar	JUL 1	8 200	75	500.00	4 1								

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylan		artment of h		Mental Hy	giene	001 = 1
	Dhysisi		1. Decedent's Name (First, Middle, L.	ast)				2. Date of De		3-Tirhe of Death
	Physici /Medi		KEITH	SAMUEL		THOM		Month OG	28 2005	unterener
	Examir	ner	4a. Fecility Name (If not institution, gi				or Location of Dea	ith	4c. County of Death	
	Funeral		214 Poplar Street, 5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	Fruitla:	If Under 24 Hr		Wicomico	
	Director		215-62-1953	1⊠M 2□F 49	Yrs.	Months Days	Hours Mir	i. (Month, Da	6, 1956 Mary	place (State or Foreign Intry)
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	v. Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show Linust be notified at	ō								1 Yes 2 □ No
	r 288	Director	Maryland Wicomic 10e. Street and Number	0 F	ruitlan	10f. Zip Code			10g. Citizen of What Cou	
	th with	a D	214 Poplar Street,	Apt. B		21826			USA	
		Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		Was Decedent of H	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)		
0000	rs afte	by Fi	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1□Yes 2⊠ No	Specify:		Specify: Blac	
3	within 72 hours after death with the Marylan ene. than "neturel", or Items 23a or 28a-f show the Mozical Evarutroust be notified at		15. Decedent's E	ducation		dent's Usual Occup			16b. Kind of Business/In	
א ב		Completed	(Specify only highest gi Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	kind of work done OO NOT use retire	during most of wo d)	orking		,
7	be filed withir tal Hygiene. d other than	Con	12th_		disc	okey			Radio/Media	l
and	± 5 5 5 5 €	Be	17. Father's Name (First, Middle, Las	<i>v</i> Thor	200			ıme (First, Middle,	, Maiden Sumame)	
5	2 should be and Mental Is marked (aumatic ev	ပ	19a. Informant's Name/Relationship			n Address (Street	Alice	Pural Poute Numbe	Taylo er, City or Town, State, Zip	
Z Z	₽£►=		Samuel Taylor/und		100					21801
ē,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place		Date	20c. Location - City or To	
ашпо	Pages nent of ant: If it ary or o		1 ☐ Burial 2 ☑ Cremation 3 (`4 ☐ Donation 5 ☐ Other (Speci	Hemoval from State	-	Cremator	AL	130/2005	Salisbury, Ma	ruland
ğ	permit. Departr Importa any inj		21. Signature of Funeral Service Lice					13 Jersey	y Road - Sali	isbury, MD
U	80 E 8 8	4 5	frethe &	folley	JC	LLEY ME	MORIAL	CHAPEL		21801
			23a. Fart1. Enter the disease, or conshock, or heart failure. List only	nplications that cacced the death one cause on each line.	n. Do not ent	er the mode of dyir	ng, such as cardia	ic or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. KENAL		FAIL	IRE			Onset and Death
	Examiner			Due to (or as a consequence of the consequence of t	uence of):	DIAR	1			
		<u>e</u>	Sequentially list conditions,	b. Dira to (or as a nonsequ	uanna of):	DIA	EIES			
	outed od ransit	Examine	any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
Ž.	e exerian ar	Exa	resulting in death) Last	Due to (or as a consequ	uence of):					
0/0	cate be executed physician and the burial-transit	dlcal	•	d						
9 X0	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit		IF FEMALE:	23c. If yes, outcome of pregna	ncv		-			
0	atten atten I for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal	death 3	Ectopic pregnancy Other (specify)	1		23d. Date of delive Month	ery Day Year
į.	that the death ed by the atte detached for	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		- Cirior (specify)				
'n.	iw requires that the s been signed by t should be detach	by P	Part II. Other significant conditions	contributing to death but not resu	ulting in the ur	iderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to the	he cause of death?
cords,	equire en siç ould t	ed	HYPERTENSION	J				101	Yes 2□No 3□Prob	pably 4 Unknown
ວ	law ri as be	Completed	ANEMIA					24a. Was	an 24b. Were auto	psy findings available mpletion of cause of
= =	iicien: The lav certificate has rector, page 2	Con	DEPRESSION					perfo 1 ☐ Yes	rmed? death? 2 No 1 ☐ Yes	2X No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	icien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		2□ DOA Oth	00	ath (Check only o	Children and the control of the cont	m- 7W
5	Phys r this ral dis	1; To	1 X Yes 2 □ No 27. Manner of Death	1 Inpatient 2	ER/Outpatien 28b. Time of	28c. Injur	4 Nursing i		dence 6 Other (Specify now injury occurred	y)
101510	nding th: : Afte e fune	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	k?ື Yes 2 □ No		iow injury occurred	
2	Atter	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		me, farm, stre	et, factory, office		28f. Location (S	Street and Number or Rura	il Route Number,
5	itel or rs afte el Dii led in	Cerl		building, etc. (Specify				City or Ton	vii, State)	
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate h completely tilled in by the funeral director, page	edical	29a. Certifier 1 Certifying P. (Check only one) 2 Medical Exa	hysicien: To the best of my kno- miner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the tin estigation, in my o	ne, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) and manner as si date and place, and due to	tated. the cause(s)
	Fo the within Fo the comple	Me	29b. Signature and title of certifier	manus		29c. Licens	e number		29d. Date signed (Month,	Day, Year)
)			1 Mahada	11.7	110	P-1	0060515	-	6/30/05	
			30. Name and address of person who	completed cause of death (Item					•	
			M-THIMMAKAYI	APPA, 614 B	ENSTE	RN SI	HAME DI	, SALIS	BUNY AD	21804
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Revistrar's Signar	ture	hours,	•			·

	š		1- For Amend Item #2				rtment of H		l Mental Hy	giene	05	231.52		
	Physici	an.	1. Decedent's Name (First, Middle, L	ast)					2. Date of De	eath Day	Year	3. Time of Death		
	/Medic		Frances	Gernel]	<u> </u>		Thomas		June	30	2005	12:32 A ^M		
	Examin	er	4a. Facility Name (If not institution, g.			Ì	4b. City, Town, or		ath		ty of Death			
			11009 Clinton Av 5. Social Security Number 6.		(In yrs. last bir	rthday)	Hage1	stown If Under 24 H	rs. 8. Date of Bi		shingt			
	Funeral Director		212-14-7177	1 M 2 TX F		Yrs.	Months Days	Hours Mi		ay, Year)	Mary	* /		
	р.		Usual Residence of Decedent						- Julie 3	,, 1721	rial y	Land		
	arylar show	-	10a. State 10b. County		10c. City, Tow						1	Od. Inside City Limits		
	28a-f	Director	MD Washin 10e. Street and Number	ngton	Hager	sto						1 ☐ Yes 2 No		
	with t	늅					10f. Zip Code 21740			10g. Citizen of	S.A.	try?		
	ns 23	Funeral	11009 Clinton Av	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of His	snanic Origin?	Specify Yes or No		ice - Americ	an Indian		
36	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23e or 28e-f show event, the Medical Examinat must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		lf If	Yes, specify Cubar ☐ Yes 2 No	Specify:	erto Rican, etc.)		ack, White,	etc.		
21215-0036	2 hou	ted	15. Decedent's E	ducation	16a.		ent's Usual Occupa			16b. Kind of I				
215	thin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+	-)	life. E	kind of work done d O NOT use retired)	uring most of w	orking			,		
	e filed within al Hygiene. other than vent, the Me	Con	9			tte						ufacturing		
Maryland		Be	17. Father's Name (First, Middle, Las	t)					: Name (First, Middle, Maiden Sumame) ie Shank					
3	should be and Mental s marked o umatic eve	ဥ	Norman S. Smith 19a. Informant's Name/Relationship	(Time Brint)	105	8.4 a 10 a	Add /0							
Ma			Edwin A. Thomas/				g Address <i>(Street</i> a dann Road			97, City or Town	n, State, Zip	Code)		
ē,	Health tem 27 l		20a. Method of Disposition	Date I	20c. Location	- City or To	wn, State							
e E	Pages ent of nt: If i		1 N Burial 2 ☐ Cremation 3 3 4 ☐ Donation 5 ☐ Other (Spec	6/2005	Hagers	town	MD							
altimore,	permit. Pages of Popartment of Himportant: If ite any injury or ot once.	1	21. Signature of Funeral Service Lice		nobe i		n Cemeter Name and Address							
m	Depar Impor any ir	10	S. Warle So	TA			01 Pennsy					-		
8760,	Physician /Medical Examiner bubbasician and site partial-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a	consequence	oi):	erar W	on My	ICALDIA	INF	ane Tro	Onset and Death		
P.O. Box 6	that the death certifed by the attending detached for use a	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown Part II. Dther significant conditions	23c. If yes, outcome o 1	Fetal death me of death	5 🗆	Ectopic pregnancy Other (specify)	n in Part I.	23e. Did t	M		y Day Year e cause of death?		
rds	w requires been sign should be	ed b	HYPERTENSIO.	~					10	Yes 2 No	3 🗌 Proba	bly 4 □Unknown		
Vital Records,	The law re ate has bee page 2 sho	Completed	/						24a. Was autop perfo 1 Yes	osy irmed?/	Were autop prior to com death? 1 \(\text{Yes} \)	sy findings available pletion of cause of		
/ita	yslcian: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?					26. Place of De	eath (Check only o		163 2	110		
of V	di is	2	1 ☐ Yes 2 ☑ No	Hospital:	- 2□ER/Ou	tpatient	3 DOA Other	4 Nursing	Home 5 💢 Resid	dence 6 🗆 Ott	ner (Specify)			
n o	ing Ph	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. T	lime of njury	28c. Injury Work?	?	28d. Describe	now injury occur	rred			
isi	Attending r death. ector: After by the fune	cat	2 Accident investigate 3 Suicide 6 Could not		At home to			es 2 No	206 (// //-	24 4 4 4 4				
Division	if or Attendate after death Director:	Certification;	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)	im, sire	ы, тастогу, опісе		City or Tov	Street and Numi vn, State)	oer or Hurai	Houte Number,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying P	hysicien: To the best of miner: On the basis of each manner state	examination and	, death d/or inve	occurred at the time estigation, in my opi	a, date and place nion, death occ	e, and due to the curred at the time,	cause(s) and m	anner as sta	ted. the cause(s)		
	To the within To the comple	Me	29b. Signature and title of certifier	- State			29c. License	number		29d. Date signe	ed (Month, D	ay, Year)		
			3/100 41	A TO	SMO		Don	5/29	5-	June 0	1 7	0.05		
			30. Name and address of person who	completed cause of dea	áth (Item 23a) (Туре, Р	rint) 720,	312000	c FAMIL	y Pra	C716			
3H	-8		11110 MEDICA CAMI	ous Ro. Sul	4 107,	H	ALENSTO	wa Me	2174	2				
:	Sta Registr	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)												

Richard Townsend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Unpend item#1,23a,PII,27,28a-f, perME,0854,4/15/06 TT

Amend item#1,perME,0855,5/5/06 TT

Cartificate of Death 05-4628 \KG Certificate of Death 1. Decedent's Name (First, Middle, Last) Richard Ernest Townsend, Jr. 2. Date of Death **Physician** Cwncend July 9, 2005 RICHARD ERNEST TOWNSEND, 5:24 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6727 Riverdale Road Riverdale
If Under 1 Year | If Under 24 Hrs. Apt. Prince George's 5. Social Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Hours 1X M 2□ F Days Min Director Yrs. 217-72-7678 49 31, 1955 Washington, DC Usual Residence of Decedent Maryland 10a. State 10b. County 28e-f show 10c. City, Town or Location traumatic event, the Madical Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 No MD Prince George's Riverdale the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 <u>6727 Riverdale Road, APT J</u> Funerai 20737 U.S.A. Items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after Black, White, etc. I □ Yes 2 ☑ No f Yes, Give Year or Dates: 1 Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 ò þ 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) 12 Cabinet Maker Carpentry marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental 2 Richard Ernest Townsend, Sr. Marie Annette McClean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 item 2 other Jason R. Townsend, Son 1433 Park Avenue, Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages nent of h Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 07/13/2005 | Alexandria, Virginia 21. Sign the of Fune al Service Lice usee 22 Name and Address of Facility Gasch's Funeral Home, P.A. 393 4739 Baltimore Avenue, Hyattsville, Maryland Part 1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Methadone intoxication disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 attending physicien by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery ō 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? page 2 should be Completed Cirrhosis of the liver 2 No 3 Probably 4 □Unknown certificete has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No autopsy performed? 1 es 2 No After this certifice funeral director, I Be 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Yes 2□No Hospital: Other $_{4\,\square\,\text{Nursing Home}}$ 5 Residence & Other (Specify) at Scene Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Hospital or Attending 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 4 hours after death 2 Accident 1 ☐ Yes 2X No Fnd 7/9/2005 Fnd 2:00 p filled in by the unk 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6727 Riverdale Rd 4 | Homicide within 24 hours House Apt J Riverdale, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Symmetrical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME July 10, 2005 IW rule 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 MANGO (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

1 2 2005

	and the second s	partment of Health and Mental Heertificate of Death	ygiene Reg. N2 1151
Physician /Medical	anawa D. Thomas	2. Date of D Month JUNE	
Examiner	A PP 100 A4 A4 A4 A A A A A A A A A A A A A A	4b. City, Town, or Location of Death BALTIMORE	4c. County of Death
Funeral Director	5. Social Security Number 220-86-1305 6. Sex 33 Yrs	y If Under 1 Year If Under 24 Hrs. 8. Date of B (Month), 2 Min. Days Hours Min. Dec 2	orth Year) 9. Birthplace (State or Foreign Country) Maryland
death with the Maryland ms 23e or 28e-f show Imust be rotified at	10a. State 10b. County 10c. City, Town or	Location CSVille	10d. Inside City Limits 1 ☐ Yes 2 🛣No
uter death with the Marritems 23a or 28a-f s	10e. Street and Number 3312 Major Denton Dr.	10f. Zip Code 20705	10g. Citizen of What Country?
hours after des tural; or Items al Examination	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes ²CNo Specify: 	14. Race - American Indian, Black, White, etc. Specify: Black
72 na na	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 th College (1-4or 5+) 4 yrs Pa	cedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired) role Clerk	16b. Kind of Business/Industry U S Dept. of Justice
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The law ate has b page 2 sl		24a. Was auto perf 1 N Yes	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hompletely filled in by the funeral director, page Medical Certification; To Be Com	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpat	of 28c. Injury at Work? PM 1 Yes 2 No 28d. Describe Optivation (City or To	idence 6 Other (Specify) how injury occurred of motorcycle that COHid 1 Car & (Street and Number or Rural Route Number, wn, State) Randolph Rd and
To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the	Cause(s) and manner as stated
To th To th comp	29b. Signature and title of certifier Mind Mind Mind Mind Mind Mind Mind Mind	29c. License number OCME	29d. Date signed (Month, Day, Year) JUNE 25, 2005
	30. Name and address of person who completed cause of death (Item 23a) (Typellow) LING LT , m D	9, Print) 111 Penn Street Balt:	imore, Maryland 21201
State Registrar	31. Date filed (Month, Day, Year) 32. Regran's Signature	A.M.	

State of Maryland / Department of Health and Mental Hygiene Regisamend ITEM #23a PER Phy C846 896416394910 Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Milton Gerald Tarver June 20. 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 18 9. Birthplace (State or Foreign Year 1939 1**X** M 2□ F 286-30-6381 Director 66 Ohio Usual Residence of Decedent the Maryland 10b County injury of edger traumatic event, the Medical Examinational De notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Howard Columbia X Yes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 6940 South Carlinda Avenue 21046 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1969 – Universe 2 □ No 1969 – If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No λq 3 Widowed 4 XDivorced African American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physician Medica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fort Tarver Mary Butler 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is rr any injury geather traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alisa T. Redd / 3909 Silver Maple Court, Rockville, MD daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory ` 4 ☐ Donation 5 ☐ Other (Specify) 6/30/05 Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Wash. D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death COLON Immediate Cause (Final Physician Prostate Cancer Metastatic disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of, The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physiclan Physician/Medical use as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 24 No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \square Nursing Home 5 \square Residence $\sqrt[8]{\square}$ Other (Specify) hospice2 1 ☐ Yes 2X No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After Certification: Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours a the Funarat Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 24 (Check only one) 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) BR 4216114 2+1 kre June 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Rajagopal, M.D. 6001 Muncaster Mill Road, Rockville, MD 31. Date filed (Month, Day, Year) 32/Registrar's Signature State

DHMH 17 Rev 1/2001

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			Shady Grove Adve		ital			cvil]				M	ontgo	mery	7	
	Funeral Director		5. Social Security Number 216–25–6467 Usual Residence of Decedent	. Sex 7. A 1 M 2 F	ge (In yrs. last I 81	yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, D 09/25	av. Year	3	9. Birthr Cour Chir	olace (State htry) 1a-Hon	or Foreign
	land ow		10a. State 10b. County		10c. City, To	wn or Lo	cation							1	0d. Inside (City Limits
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920	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantral must be routiled at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Test 2 1 1 Test 2 1 1 Test 2 1 1 Test 2 1 1 Test 2 1 1 Test 2 1 1 Test 2 1 1 Test 2 1 1 Test 2 1 1 Test 2 1 1 Test 2 1 1 Test 2 1 Tes	Ever in U.S. ? No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race Black Specify:	, White,		
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	10		30. Name and address of person what 11908 DARNESTO	o completed cause of	death (Item 23a) (Type, I	Print) N IORT	ELS	ON	۷.	LU1, 2	1.D.				
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 1 2	005 Regist	rar's Signature	fre	Si.									

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended #23a perMD FCHD, KS Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARY ANN WEATHERALL JULY 8:07 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 23 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 1941 216-38-0066 Director 64 Yrs Petersville MD Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits or items 23a or 28a-f shov tractings be notified at Director MD Frederick Frederick 1 ☐Yes 2X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other traumest- once. with 6441 Jefferson Pike 21701 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIH - Bethesda, MD 12 Secretary 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Millard Franklin Hahn Frances Louise Trail 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 East "D" Street, Brunswick, MD Sherri Sigler, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ¹ 4 □Dogation 5 □Other (Specify) Hagerstown Crematory 7/5/05 Hagerstown, MD 21. Signature Service Librar William John T. Williams Funeral Home Barbara A. Williams, Owner 100 Petersville Road, Brunswick, MD 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) mus /Medical a consequence of Examiner Cytomegalo Virus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy į in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the No 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, funeral director, page 2 should be 2 No 3 Probably Be Completed 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death ate of Injury (Month, Day 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Accident Year 5 Pending after death death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the 29b. Signature and title of pertitier 29c. License number 29d. Date signed (Month, Day, Year) 1 31 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who co 5 Robert L. Kaufmann, MD 300 West 9th Street, Frederick, MD _ 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

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	Physic	ian	Decedent's Name (First, Middle, Las	•					2. Date of Month		Day Yea	3. Time of i	Death
	/Medi		Cheryl Marie Wolf			,			June	29,	2005	6:55	A M
	Exami	ner	4a. Facility Name (If not institution, give			4b. City,	Town, or Lo	cation of Death			4c. County of De		
			3500 Moylan Driv 5. Social Security Number 6. Se			Bowi		Heder Od the			Prince (
	Funeral Director			ΠM 2ΓXE	rs. last birthday) Yrs.	If Under Months		Under 24 Hrs. Hours Min.	8. Date of 1 (Month, 2/7/1	Birth Day, Yea	9. E	irthplace (State or Country)	
			Usual Residence of Decedent	4	1				2///1	.964	Was	shington,	DC
	yland how		10a. State 10b. County	10c.	City, Town or Lo	ocation						10d. Inside City	y Limits
	B-f s	ctor	Maryland Prince G	eorges Bo	wie							1 🌠 Yes	2 🗌 No
	ith the	Funeral Director	10e. Street and Number			10f. Zip	Code			10g. (Citizen of What	Country?	
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	r deg	Tue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced	ent of Hispa	nic Origin? (Spe Mexican, Puerto	cify Yes or I	Vo-	14. Race - An Black, Wi	nerican Indian,	
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00	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Madical Examirer must be notified at	d b	3 ☐ Widowed 4 ☒ Divorced	Year or Dates:				· ·			Specify: Wh		
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212	iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		ce Man				De	ental Gr	OUD	
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<u>a</u>	and be denta rked ric ev	To B	William Wolfe II	I				laureen '			-,		
Maryland 21215-0036	12 should be filed within hand Mental Hygiene. 7 Is marked other than "traumatic event, I'm Max	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address		Number or Rura			or Town, State	Zip Code)	
	Health tam 27 I		Maureen T. Reedy/	Mother				ve Bowi					
ore	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Modical Examiral Trust Be notified at		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	20b	. Place of Dispo cemetery, crer	sition (Nam	e of her place)	D	ate	20c.	Location - City of	or Town, State	
Ĕ	Pag ment ant: I ury o		`4 □Donation 5 □ Other (Specify	Torrioral Horri State	ate of H			7/2/	2005	Sil	ver Spr	ing, MD	
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licens	600	22	. Name and	d Address of	Facility Robe	ert E.			ral Home	
ш	20599		LILLY					lis Road			D 20715		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	- Cgn	<i>P</i>	of dying, su	uch as cardiac o	r respiratory	arrest,		Approximate Interval Between Onset and De	een
8760,	cate be executed obysicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consi									7130
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ls, P.	ign bed	by	Part II. Other significant conditions co	ntributing to death but not re	esulting in the ur	nderlying car	use given in	Part I.			,	to the cause of dea	
0.00	w requir	etec							1	Yes	22No 3 F	robably 4 Dun	known
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Ζij		Be	25. Was case referred to medical examiner?	Hospital:			Othor	Place of Death		one)			
	Phys rathis rathi	. To	1 Yes 2 No	1 ☐ Inpatient 2	☐ ER/Outpatient 28b. Time of			□ Nursing Hom			6 □Other (Spe	ecify)	
on	ding Ph h. After th funeral	ton	1. ■Natural 5 □ Pending	(Month, Day Year)	Injury	M 201	c. Injury at Work? 1 ☐ Yes		8d. Describe	now inj	ury occurred		
Division	l or Attending after death. Director: After d in by the funer	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, stre				8f. Location	(Street a	nd Number or F	ural Route Numbe	
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	the Hos iin 24 ho the Fun ppletely f	ledical	one)	sician: To the best of my ki ner: On the basis of examir and manner stated.	nowledge, death nation and/or inv	occurred at estigation, i	t the time, da n my opinior	ate and place, at n, death occurre	nd due to the d at the time	cause(: , date ar	s) and manner a nd place, and du	s stated. e to the cause(s)	
	To To no	Σ	29b. Signature and fittelof certifier	3 11.		29c.	License nur	mber		29d. D	ate signed (Mon	th, Day, Year)	
7		-	1 / 0	V NO			DUS	150/		ノレ	he re	1 2005	
			30. Name and address of person who or	MO 900	Berry	1 49	OH	500	Ann	goiol	15 110	2149	
	Sta Registr	.6	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	book							

	-	State Registrar	State of Maryla	•	artment of H		Reg. N	200 =
Physicia /Medic Examina	al -	Decedent's Name (First, Middle, Last) Nelson Werner 4a. Facility Name (If not institution, give st.)			4b. City, Town, or	Location of Death		8, 2005 c. County of Death
Funeral Director		Frostburg Village Nursin 5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ng Care Center 7. Age (In yr. 90	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year 08-Jul-1915	9. Birthplace (State or Foreign Country) Maryland
the Maryland 28e-f show	Director	Maryland Garrett 100. Street and Number	Fros	City, Town or Lo	10f. Zip Code		10g. C	10d. Inside City Limits 1 ☐ Yes 2 👿 No
urs after death v al', or items 23s	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 _ Yes _ 2 M No If Yes, Give Year or Dates:	16a. Dece	21532= Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No dent's Usual Occupa kind of work done of	n, Mexican, Puerto Specify:	ecity Yes or No-Rican, etc.)	
be filed tal Hyg d othe event,	To Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 6 17. Father's Name (First, Middle, Last) John Werner	College (1-4or 5+)		DO NOT use retired,	18. Mother's Name	truci e (First, Middle, Maide	
s 1 and 2 shows 1 and 2 shows 1 tem 27 is m other traum		19a. Informant's Name/Relationship (Type Donna Werner 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Re	daughter	2493 Fi	ng Address (Street a nzel Road sition (Name of matory or other place	Frost	al Route Number, City	or Town, State, Zip Code) Maryland 21532 .ocation - City or Town, State
permit. Pages Depertment of important: if it any injury or o		* 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee			2. Name and Addres	s of Facility	ost Ave., Fros	Maryland stburg, MD 21532
	lical Examiner	Affock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.		equence of):	/ cyculor	, sec	dent	Interval Between Onset and Death
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n 24 hou n 24 hou ne Funer bletely fill	edical Certification:	3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Coculd not be determined 1 Coculd not be determined	28e. Place of Injury - At building, etc. (Spec sian: To the best of my ker: On the basis of examinand manner stated.	<i>cify)</i> nowledge, deat	h occurred at the tim	e, date and place,	City or Town, Stat	
not 2/1	M	29b. Signature and title of certifier 30. Name and address of person who com Hacit S. Sidhu	Humipleted cause of death (Its	111	101	907	and MD 2	ate signed (Month, Day, Year)
Stat Registra		31. Date filed (Month, Day, Year)	32. Jegistrar's Sig	nature	rock		IN/O', I'' Z	-,

			1 - For State Registrar	State of Maryla		artment of H		, 0	000	- 0	01.60
	Physici	an T	1. Decedent's Name (First, Middle, Last)				Journ	2. Date of Deat	_	ear C ₃	3. Time of Death
E.	/Medic	al	Miriam L. A					July	17, 200		10:50A M
*	Examir	er	4a. Facility Name (If not institution, give s 2701 Coxswain Pla			4b. City, Town, or	Location of De apolis	eath	4c. County of Anne A		-1
60	Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 F	Irs. 8. Date of Birth			e (State or Foreign
	Director		102 - 20 - 5725	M 2XF	79 Yrs.	Months Days	Hours M	lin. (Month, Day, Nov. 22	, 1925	Fran	nce
	and		Usual Residence of Decedent 10a, State 10b, County	10c. C	ity, Town or Lo	cation				104	Inside City Limits
	Maryl -f eho	to	Maryland Anne Aru			polis				1	1 ☐ Yes 2 No
	r 28e	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	at Country?	?
	th with	al D	2701 Coxswain Pla	ce		2140)1		US	SA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of Hi	spanic Origin? n, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race -	American I White, etc.	
36	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or Items 23c or 28e-1 ehow ent, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give X Year or Dates:		1 ☐ Yes 2X No	Specify:			White	
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Maryland 21215-0036	ed wil	Completed		4*	Н	lomemaker			Own H	Iome	
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Š	should id Me mark matic	은	Isadore Levy 19a. Informant's Name/Relationship (Ty)	ne Print)	19h Mailin	n Address (Street a		jorie Elia Rural Route Number		ato Zin Co	udo l
<u>≅</u>	nd 2 sulth an and 2 sulth an an an an an an an an an an an an an		Jeanne K. Aelion,	, ,	1.			Bowie, Ma	1919.7		09/
re,	s 1 ar		20a. Method of Disposition	20b.		sition (Name of natory or other place			20c. Location - Ci		, State
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 X Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)			matory Ir		/18/05	Baltimor	e, Ma	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23c or 28e-f ehow any injury or other treumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Liganse Thomas Gregor	90	222 C	Name and Address	Society	y Of Maryl ad Baltimo	and, Inc.	.11	21 220
	· -		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the de	ath. Do not ent	er the mode of dying	g, such as card	diac or respiratory arm	ore, Mary est,	Ap	ZIZZO pproximate terval Between
	Enysician	0 10	Immediate Cause (Final disease or condition		ance						nset and Death
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Box	that the death certificed by the attending postering detached for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of Month		y Year
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٥,	res that signed b	by PI	Part II. Other significant conditions con	ntributing to death but not re	sulting in the ur	nderlying cause give	n in Part I.	23e. Did tol	bacco use contribi	ute to the c	ause of death?
ğ	w require been sig should b	ted						12 Ye	as 2□No 3	Probably	y 4 🗆 Unknown
Records,	e lawr has be je 2 sh	Completed						24a. Was a autops	v - nric	re autopsy	findings available etjon of cause of
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Vita	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Othe	AF:	Death (Check only on			
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Division of	r Atte ter de irecto ir by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stri	eet, factory, office		28f. Location (St City or Town	reet and Number	or Rural Ro	oute Number,
	urs affore or a file or a							N. C. C. C. C. C. C. C. C. C. C. C. C. C.			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phys 2 ☐ Medical Examir	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	n occurred at the tim vestigation, in my op	e, date and pla pinion, death or	ace, and due to the ca courred at the time, d	ause(s) and mann ate and place, and	er as state d due to the	ed. e cause(s)
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			1 1 0	W/W		100	>140	1 3	Tuly 1	8,2	03
	3		30. Name and address of person who co	+ 110	400 PC	Print)	ead #	7300 A	nnapolis	MOZ	2 (40)
	Sta Registi		31! Date filed (Month, Day, Year) JUL 1 9 200	32/Registrar's Sign	de spe	will !			1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HELEN ARMSTRONG 2005 L. JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** GLEN BURNIE ANNE APUNDEL BALTIMORE WASHINGTON MEDICAL CENTER 8. Date of Birth
(Month, Day, Year)
Sep. 14, 1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)

WV **Funeral** 6. Sex 7. Age (In yrs. last birthday) 10 M 2 F Months Days Hours Min 235-30-7159 Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10a, State 10d, Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic svent, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 949 Oakdale Circle 21108 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after de I Hygiene. other than "natural", or Item: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 X Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Continental Can Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumering once. Canner Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cecile Lilly Maggy Lilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12915 Cunninghill Cove Road, Baltimore, MD 21220 Mr. John Armstrong / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery Jul. 18,2005 Brooklyn, MD ³ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Fineral Service Licens 1 Second Avenue S.W., Glen Burnie, MD 21061 Part1. Enter the disease, or complications that cased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician PNEUMONIA disease or condition resulting in death) 3 weeks /Medical Due to (or as a consequence of): Examiner CHPONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) 3 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed nding physician and use as the burial-transit resulting in death) Last Box 68760[©] Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Atrial Fibrillation 1 Yes 2 No 3 Torobably 4 Unknown Deep Venous Thrombosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No BACTEREMIA 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 No 은 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of Certification; 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death Accident hours after deat 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 T Homicide within 24 hours at To the Funeral D completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one)

P.O.

Vital Records,

of

State Registra

MATTHEW PARK, M.D. JUL 1 9 2005 31. Date filed (Month,

Matthew K.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

305 HOSPITAL DR. STE. 305, GLEN BURNIE, MD 21061 32. gistrar's Signature

M.D

29c. License number

D 47575

29d. Date signed (Month, Day, Year) July 14, 2005

		-	For State Registrar	State of M	faryland /		artment of H			-	giene Reg. No. ⁴	2001	- 001	
	Dhyciai	20	1. Decedent's Name (First, Middle, L.							2. Date of De	ath Day	Year	S. Tirolo on	Dan 4
	Physici /Medic	al	Harriett	Ε.		ddie				July 1	7, 2	2005	15:45	М
	Examin	er	4a. Facility Name (If not institution, gr Southern MD I		r)		4b. City, Town, or Clin		of Death			County of Dea		
-	Funeral				Age (In yrs. last i	birthday)	If Under 1 Year			8. Date of Bir	th		Georges	
L	Director			1□M 21€ F	80	Yrs.	Months Days	Hours		(Month, Da 1 0 – 0 7 –	y, Year)	NC	rthplace (State or Country)	. G. O.g.
	DU * 1.55		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation						10d, Inside Cit	v Limite
	Maryla f sho	ō	MD PG		700. 01,9, 10	,,,,,,,,	Temple	Hi1:	1s				1 XYes	•
	28e-	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What C	Country?	
	th with		4517 Henderso	n Rd.			207	48				USA		
	r dea	Funeral	11. Marital Status	12. Was Deceder Armed Forces	s?	13.	Was Decedent of H	lispanic C an, Mexic	rigin? (Spann) an, Puerto	ecify Yes or No Rican, etc.)	- 1	4. Race - Am Black, Wh	erican Indian, ite, etc.	
36	hours after death with the Maryland tural; or Items 23a or 28e-f show at Examiliar must be mylified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 □Yes 2 ☑ If Yes, Give Year or Dates	∑ No ⊶		1 □ Yes 2 □ No	Specif			1	Specify:	Black	
2	2 hou	ted	15. Decedent's I	Education		Sa. Dece	dent's Usual Occup	ation			16b. Kin	d of Busines	s/Industry	
215	within 72 ene. than "nel	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4o	or 5+)	(Give life.	kind of work done of DO NOT use retired Nurse	during mo d)	ost of work	ing	т	rivat		
2	be filed within 72 hours after death with the Marylan tal Hygliene. d other than "netural", or Items 23a or 28e-f show event. The Madical Examination institution at	Con	10				Nuise						.е	
Maryland 21215-0036	2 should be filed wo and Mental Hygie	Be	17. Father's Name (First, Middle, Las Arthur	Boone				Car:		e (First, Middle,	Syke			
<u> </u>	should Ind Menial Ind Menial Indianation	2	19a. Informant's Name/Relationship		1:	9b. Mailir	ng Address (Street						Zip Code)	
<u>S</u>	nd 2 salth ar 27 ls		Ruby Bullock/				Henders							48
ore,	es 1 a of Hea fitem rothe		20a. Method of Disposition	□Damaual from Stat	20b. Place ceme	of Dispo	sition (Name of natory or other place	(e)		Date	20c. Loc	cation - City o	r Town, State	
Ĕ	Pages ment of ant: If it ury or o		1 ★ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec	oify)	ie I.	oln	Memoria	1	07-23			land,		
Balltimore,	ermit. Pages 1 and 2 should epartment of Health and Men portant: If item 27 is marke ny injury or other traumatic.		21. Signature of Funeral Service Lice	ense			2. Name and Addre							2000
	402 * 0		23a. Part1. Enter the disease, or co	molications that caus	ed the death D		22 N . C					ningt	Approximate	
	Dhusisian		shock, or heart failure. List onlinediate Cause (Finat	y one tause on each	i line.		0		1 1	-			Interval Betw Onset and D	veen
	Physician /Medical		disease or condition resulting in death)	Due to (or a	as a consequent	oce	erala	u	ya	icho	^			
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	and and and	Examiner	that initiated events resulting in death) Last	c Due to (or a	as a consequenc	e of):								-
8760,	cate be executed physician and the burial-transit	dical E		·										
9	tificate ig phy as the	ledic		0.										
Вох	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1□Live birth	ne of pregnancy 2 Fetal dea	ath 3	Ectopic pregnancy	,			23	3d. Date of de		
0	ne dea the at hed fo	/sici	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant 9□Unknown	at time of death		Other (specify)					Month	Day Y	ear
م.	that the de led by the a detached f	Phy	Part II. Other significant conditions	contributing to death	but not resulting	g in the u	nderlying cause giv	en in Par	t I.	23e. Did t	obacco us	se contribute	to the cause of de	eath?
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000	sw requires s been si	Completed								24a. Was	an	24b. Were a	autopsy findings a completion of ca	vailable
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/isi	I or Attendi after death. Director: A I in by the fu	flca	3 ☐ Suicide 6 ☐ Could not	he	Injury - At home,	farm, str	eet, factory, office					Number or F	Rural Route Numb	per,
á	s after at Direct	Certification:	4 Homicide	building,	etc. (Specify)					City or To	wn, State)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical ((Check only 2 Medicel Ex	Physician: To the be- aminer: On the basis	st of my knowled	dge, deat	n occurred at the tin	ne, date a	and place,	and due to the	cause(s) a	and manner a	as stated.	
	thin 2, the f	Medi	one) 29b. Signature and title of certifier	and manner	stated.		29c. Licens						nth, Day, Year)	
	7 × 7 8		Salar Maria Control	Maria	~ M	0	1016	7/23	2.2			7/18/	0	
7	10		30. Name and address of person wh	o completed cause of	of death (Item 23)	a) (Type	Print)	10-	<u>~</u>			1101	<u> </u>	
	V		John Ctatte	erson 1	M.D.	75c	Swr	allo	KJZ	7201A	CI	inton	Md.Z	0735
	Sta	-	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	1	N.							
П	Regist	rar	30L T 3 20	10 Alexan	1 11 1	4164								

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Me	•	e				
			1- State Registrer Certificate of Death	Reg. N		231.65			
	Physicia	an	Decedent's Name (First, Middle, Last)	Date of Death Month D	ay Year	3. Time of Death			
	/Medic	al	KUBERT LEO DITIRICK	July 1	8 2005	12:18 AM			
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 2525 Pot Spring Ro. Apr. L 712 Timonium	4	c. County of Death	MORE			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8	Date of Birth (Month, Day, Yea		place (State or Foreign intry)			
	Director		215-03-6715 TO YES	EB. 15, 19	15 BAC	TIMURE, MO			
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
	• Man	tor	MO BALTIMORE TIMONIUM			1 Yes 2 No			
	or 28	Director	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Cou	intry?			
	s 23a			fy Vac or No-	14. Race - Ameri	ican Indian			
(0	r Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 1 Never Married 1 Yes 2 No Specify: 1 Yes 2 No Specify:	can, etc.)	Black, White				
903	hours after death with the Maryland tural, or Items 23a or 28e-f show at Examinat must be notified at	d by	3 Wildowed 4 Divorced Year or Dates:		Specify: LL	ite			
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	be filed ntal Hygi od other event, I	Be C	17. Father's Name (First, Middle, Last)	First, Middle, Maide					
Maryland		10	GEORGE BITTKICK MAKE		1) OUGA				
Mai	id 2 should th and Mer 27 Is marke treumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural II MARGUERITE BITRICK-WIFE 2535 RT Spring RD.	APT L 7	Time	NIUM MD			
Je,	es 1 and of Healt fitem 2 r other		20a Method of Disposition 20h Place of Disposition (Name of Da	-	Location - City or T	own, State			
imo	Pag nent int: I	ARKUILLE	= MD.						
Baltimore	permit. DepartmImporte any inju		21. Signature of Funeral Service Licensee		or en	5 FUNERAL			
	202 4 4		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	respiratory arrest.	Timen	App eximate Interval Between			
	Pnysician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Onset and Death			
		<u>_</u>	disease or condition resulting in death) Due to (or as a consequence of):			Years			
Į,			Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	uted Insit	Examine	cause. (Disease or injury						
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68760	death certificate be executed e attending physician and od for use as the burial-transit	dicai							
9 X	death certificate b attending physic of for use as the b	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		23d Date of dolla	10P4			
Box	death a atten d for u	ician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23d. Date of delivery Month Day Year					
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Ś	The law requires that the ate has been signed by the bage 2 should be detache				ouse contribute to the cause of death?				
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Record	The law ate has page 2			autopsy performed?	prior to co	opsy findings available ompletion of cause of			
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of V	Physicien: this certific ral director,	To B	1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Nursing Home 6 Other (Specify)						
	ttending F death. tor: After the funera	tion:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28 Vork? 2 Accident investigation M 1 1 Yes 2 □ No	d. Describe how inj	ury occurred				
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Ö	Dir C	Cert	4 Homicide building, etc. (Specify)	City or Town, Sta	10)	3)			
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edical	29a. Certifier (Check only one) (Check only on						
	To the within 2 To the complet	Med	29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Month)	Day, Year)			
	11		1 6 en 8 Com 5) 176271	+44	7/19/03				
1	a m	D 24271							
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature									
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/19/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature									

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 2005° Ann Marie Bailey 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Chesapeake Arnold Anne Arundel 5. Social Security Number 8. Date of Birth
June 14, 1919 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Minnesota Funeral 6. Sex 7. Age (In yrs. last birthday) Days Hours 1□M 20 F 86 Yrs. Director 469-14-6291 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Director Maryland Anne Arundel 1 ☐ Yes 2 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 St. Margarets Drive or Items 23a 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced 'natural', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "nany injury or other traumatic event, Its Made 2008. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Butler Mary Bonner ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Bailey, Husband 1055 St. Margarets Drive Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 07/18/05 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licersee
Thomas Gregor ^{22, Name and Address of Facility} Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician Rre rovas nours disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical as the l IF FEMALE. esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ło in the past 12 mon 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 Yes 2No 1 🗌 Yes director Be 25. Was case referred o medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of perspn who completed cause of death (Item 23a) (Type rans Hours Millersulle MDa1108 Kiedina 1 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and	mental Hygiene			
			Certificate of Death	Reg. No.	5 231.67		
	Physicia		Decedent's Neme (First, Middle, Last)	2. Dete of Deeth	3. Time of Death		
	/Med				0105cm		
	Exami		4a Facility Neme (If not institution, give street and number) 4b. City, Town, or	Location of Death 4c. County of I	7,1		
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				along Dal	timore		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 1 Under 1 Year If Under 24 Hrs Age (In yrs. lest birthdey) 1 Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min.	(Month Devi Year)	Birthplace (State or Foreign Country)		
	Director		217-20-2+0+ V 00 11s	7/8/25	MA		
	Du s	_	Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location				
	ehow	_			10d. Inside City Limits		
	r 28a-f eho	용	Windsor Mill		1 ☐ Yes 2 ☐ No		
	72 hours efter death with the Maryland nature!', or frems 23a or 28a-f show dical Examiner must be notified at	5	10e. Street and Number	10g. Citizen of Wha	t Country?		
	th will	0	5009 (or ley Knad Apt. A6 2/207	_ //	CA		
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	ter des items	٦	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent of Hispanic Origin? (S	o Rican, etc.) Black, V	Vhite, etc.		
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5-0036	72 hour naturel' dicel Ex	B	Year or Dates:		Juck		
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힏	be filed tel Hygi d other event, t	Se Se		ne (First, Middle, Maiden Surname)	Maiden Surname)		
<u>a</u>	should b nd Mente marked imatic e	To Be	Benjamin F. Brown Flos	sie Washi	naton		
2	of br	-	19. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrson (Street and Number or Ru		in Code)		
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	other t		20a. Method of Disposition 20b. Place of Disposition (Name of	vay, parto, p	10 21277		
ō			1 Burial 2 □ Cremation 3 □ Removal from State Cemeter Crematory or other diace)	Date 20c. Location - City	or Town, State		
Ξ.	Part:		4 Donation 5 Other (Specify) Dath nore National	7/20/05 Baltimo	ire, MD		
Baltimore,	mit. Pege partment c mportant: If ny Injury or		21. Ignature of Funeral Service Licensee 22. Name and Address of Facility	The Same	vices		
			Vaugh C. Gre	A			
			87a82: berty Ra	· Randallstown,	, MD 21133		
	Physician /Medical Examiner		23a. Pent. Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart faiture. List only one cause on each line.	or respiretory arrest,	Approximate Interval Between		
4			Immediate Cause (Final disease or condition resulting in death)	liovaxulardis	20.50		
			resulting in death) a				
		رة ا	bue to (or as e consequence or):				
	The law requires that the death certificate be executed ate has been signed by the ettending physicien end page 2 should be deteched for use as the buriel-transit completed by Physician/Medical Examiner	Ē	D				
		X	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
68760,	bun bun		Cause (Disease or injury		i		
87	phys the						
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Box	eeth cer ettendin I for use	Physician/M	d				
	dee deet		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did tohacco use contrib	ute to the cause of deeth?		
O to the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death?			
	the del	by P		1 ☐ Yes 2 ☐ No 3 ☐	Probably 4 Unknown		
g	sign d be	용		24- 14	h Mara automorfiadione		
Ö	v require been si should I	9		24a. Was an autopsy 24 performed?	b. Were autopsy findings available prior to		
ec	law les b	ē			completion of cause of death?		
<u>—</u>		Be Completed		THE 2LL NO	1 ☐ Yes 2 ☐ No		
Vital Records,			25. Was case referred to medical 26. Place of Deat	th (Check only one)			
>		0	Hospital:				
o	Phys rthis arel d	洁	12 inpution 25 outpution 55 box	ome 5 Residence 6 Other (S	pecify)		
2	Afte fune	호	1 Maturel 5 Pending (Month, Dey Year) Injury Work?	280. Describe now injury occurred			
Division	al or Attending Pt s efter deeth. el Director: After tt ed in by the funere	Certification:	2 Accident investigation M 1 Yes 2 No				
\geq	or All	뒫	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	actory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	within 24 hours effer de To the Funeral Directo completely filled in by the	ပ္					
	Hospital 24 hours e Funerel [letely filled	edical	29a. Certifier (Check only 2 Madical Fyaminer: On the basis of ayamination and/or investigation in managing in the state of the basis of ayamination and/or investigation in managing in the state of the basis of ayamination and/or investigation in the basis of ayamination and/or investigation in the basis of ayamination and/or investigation in the basis of ayamination and/or investigation in the basis of ayamination and or investigation and or in	and due to the cause(s) and manner	as stated.		
	n 24 n 24 plete	8	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, date and place, and d	ue to the cause(s)		
	To the Within 2 To the comple		29b. Signature and title of certifier 29c. License number	29d. Date signed (Mo	onth, Day, Year)		
			Mendie Dele \$ 0058141	7/6/	<u> </u>		
7	2		1 menus pieces 50038191	1/10/0			
	4	30 Name and eddress of person who completed cause of deeth (Hem 23e) (Type, Print) SYD A Court Road. (Likentry Road) Randallstown					
_				~ / Kandalls	cour, mo 2112		
	Sta	ie .	31. Date filed (Month, Day, Year) 32. Begistrer's Signature				
	Registra	ar	1111 1 9 2005 August St. April 1				

DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Mb. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** July Grace E. Brown 15 2005 4:55 P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 □ M 2 □ F 214-46-1642 93 Yrs. Director Canada 01-05-1912 Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "naturel", or Items 23e or 28a-f show other treumetic event, the Nedical Exertic er must be notified at 1 ☐ Yes 2 No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 Rice Avenue 21228 Canada by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: Specify: White 3 ₩Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. Ih and Mental Hygiene. 7 is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Adam Spencer MacLeod Elizabeth Beers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an ent: If item 27 is a Sharon Garry - Daughter 1301 Rice Avenue Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Balto/Wash Crematory 7-26-2005 * 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, MD 21228 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician granution bew weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ausphapla Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 🗌 Yes 2 X No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury death. investigation 1 ☐ Yes 2 ☐ No 4 hours after death Funerel Director; / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) acema 127541 18, 2005 Loyar WI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore ND, 4367 tem Holling 32. Registrar's Signature State 1 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE Burks O.S.P. Dorothy /Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours Min. 07 20 16 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Nown, or Location of Death Examiner AGNES SAINT 5. Social Security Number Birthplace (State or Foreign Country)
 KY **Funeral** 6. Sex 7. Age (In vrs. last birthday) Months 1 ☐ M 2**X** F 88 Director 220-50-1487 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10a, State 10b. County nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan arment of Heath and Mental Hygiene.
ortant: If item 27 is marked other than "natural; or Items 23a or 28a-f show injury or other traumatic event, the Medical Examination in the routilised as 10d. Inside City Limits 1 Yes 2 No Director MD Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Gun Road U.S.A. Funeral 21227 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: à 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 4yrs Teacher School 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Burks Emma Blincoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Sister Ricardo Maddox</u> 701 Gun Road, Catonsville, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or QDC6. ' 4 ☐ Donation 5 ☐ Other (Specify) 7/9/05 Loudon Park Baltimore, Md 22. Name and Address of Facility
March F/H West
4300 Wabash ave, Baltimore Md 21. Signature of Funeral Service Licensee 21215 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart values. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) - Therosclcron's Physician Brainvascular lears. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medlcai as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? Year Month Day 1 Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes _2 Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ENOutpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 1 🗌 Yes filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 2005 Mann, M.D. DO056092 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CaronAlvenue Baltimore, Maryland Edanama 32. Resistrar's Signature 31. Date filed (Month, State lows Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 4:50 a.™ CATHERINE HAMMOND BRISLIN Julv 13, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Baltimore Timonium If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 4,1908 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 21 🖾 F 97 145-03-0570 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Timonium the 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 101 Washington Street U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ₹ No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: If Yes, Give 4 > Year or Dates: \$ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Retail of Health and Mental Hygi itam 27 Ia marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Forney Schultz Hattie Louise Lewis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Washington Street Timonium, Maryland21093
ce of Disposition (Name of Date 20c. Location - City or Town, State Mary Eckhart (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ital
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 7/18/05 Baltimore, Maryland 21. Signature of Funeral Service Licensee Michelle Wickefeld F.H. Inc. 1990 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complication accaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed been signed by the attending physician and should be detached for use as the burial-translt Due to (or as a consequence of): Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 this certificate 1 Yes 2X No Vital After this certification funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🛣 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deam.
To the Funeral Diractor: f investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093 JUL 1 9 2005 31. Date filed (Month. State Elen & Speck Registrar

2005

Registrar

State

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of F rtificate of			Reg. Ng		23472
	Physici	an	1. Decedent's Name (First, Middle, La	•				2. Date of De		^y 2005	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, gir	d A. Bur	gess	4b. City, Town, o	or Location of D		_	. County of Dea	7:50p M
	Lxamiii	CI	Stella MAris	Hospice		Towsor	า		E	Baltimo	ore
	Funeral		5. Social Security Number 6.		(In yrs. last birthday,		If Under 24	Min. (Month, Da	th y, Year,	9. Bir	thplace (State or Foreign ountry) cyland
	Director		218-44-1409 Usuel Residence of Decedent	· X ··· 2 ·· 1	60 Yrs.			May18,	194	5 MA1	cyland
Page 1	yiang Pow		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
, and	r 28a-f ehow	ctor	MD Balti	more	Esse	ex					1 ☐ Yes 2 No
4		Funeral Director	10e. Street and Number			10f. Zip Code				tizen of What C	ountry?
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3	or itan	Fu	Never Married 2 Married	Armed Forces? 1 XYes 2 □ N	i			n? (Specify Yes or No Puerto Rican, etc.)		Black, Whi	te, etc.
ຼັ ຊີ		Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specity:			Specify: Wh	nite
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	Hygin ther	Be Co	17. Father's Name (First, Middle, Las	")			18. Mother's	Name (First, Middle	Maidei	n Sumame)	
lan lan	e d a	ToB	Stanley I. Bu	rgess			Dori	s M. Sch	win	k	
Maryland	and h	. 11	19a. Informant's Name/Relationship	(Туре, Print)	19b. Mail	ing Address (Street		or Rural Route Numb			Zip Code)
	s 1 and 2 should of Health and Mer Item 27 Is marke other traumatic		Carl Murray		20b. Place of Disp	29 New	Jerse	y Ave. B	alt	imore	MD 21221 Town, State
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [cemetery, cre	matory or other pla Cremato	ice)	/18/05		ltimor	
	permit. Page Department of Importent: If any injury or once.		 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice 			2. Name and Addre	es of Facility				
Ba	Deparement Deparement		PR Tehn	116				Connelly e. Balti			omeofEssex
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nglications that caused	the death. Of hot er					e Mu	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	NON SM	ALL CELL I a consequence of):	UNG CANC	ER				Onset and Death
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.O. Box	The law requires that the death certilicate be executed are than been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death 3	Ectopic pregnanc Other (specify)	ey .			23d. Date of de Month	elivery Day Year
σ.	res that the contract of the c	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did t	obacco	use contribute t	to the cause of death?
rds ·	w requires been sig should bo							11	Yes 2	!□No 3□P	robably 4XIUnknown
Records,	e law re has bee	Completed						24a. Was		24b. Were a	utopsy findings available completion of cause of
æ,	The ate his page	Com						perfo 1 ☐ Yes	rmed?	death?	
Vital	yeician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?	Hospitali		Low		Death (Check only			
o d	유 유 등	. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospital: 1 Inpatie		nt 3 DOA	4 Nursi	ing Home 5 Resi			ecify) HOSPICE
on :	ding F th. After funera	tion	1 Natural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, Da	y Year) Injury	₩o	ork?]Yes 2∐No			.,	
É	in Site	Certification;	3 Suicide 6 Could not determine	286. Place of Inj	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (City or To	Street a wn, Stat	nd Number or F e)	Rural Route Number,
:	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying F	hysician: To the best miner: On the basis o and manner st	f examination and/or i	th occurred at the ti nvestigation, in my	ime, date and popinion, death	place, and due to the occurred at the time,	cause(s date an	s) and manner a od place, and du	s stated. e to the cause(s)
	To t withi To tl	Z	29b. Signature and litle of certifier			29c. Licen	se number		29d. Da	ate signed (Mon	oth, Day, Year)
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r) '		30. Name and address of person who				T		0.0	/ /	
	- CA	ate	DR. TARIQ MAHMOO 31. Date filed (Month, Day, Year)		LANEY VALI	EY RD.	TIMONIU	M, MD 2109	93		
	Sta Regist		HIL 1 9 ZUI	£7.	LU MAR	40					

JULY 14, 2005

RICHARD BURGESS

Eugene Edward Carr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-04767 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) ^{Day} 2005 July 14, **Physician** 11:51 p.^M EUGENE **EDWARD** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner University Hospital - Shock Trauma Baltimore N/A If Under 1 Year II Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. 1X1M 2□ F 117-68-6365 Director 23 03 - 14 - 1982Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b County r 28a-f ehow Yes 2□No MD N/A BALTIMORE Direct the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number other then "natural", or Itema 23a or rent, the Medical Examiner must be in 3417 CALLAWAY AVENUE 21215 death USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes = 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify.BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) EPOXY TECH CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Is marked of Pages 1 and 2 should be EUGENE CARR PATRICIA RIDOUT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Depertment of Health an
Important: if Item 27 Is:
eny injury or other traut
once. PATRICIA R. CARR/MOTHER 3417 CALLAWAY AVE., BALTO., MD 21215 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
T. Stanis laus 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7-23-05 Balto 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS STREET, BALTO., MD 21217 23a. Paper Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) multiple gunshot **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Examiner or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, ❖ Due to (or as a consequence of) Physician/Medical Se esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 🕅 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1. ✓ Yes 2 □ No 24a. Was an autopsy certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Yes 2□ No 2 ER/Outpatient 3 DOA this After thi 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Natural 5 Pending 11:12 PM subject was shot 1 ☐ Yes 2 X No death. investigation 2 Accident Found H14/05 efter death in by the Location (Street and Number or Flural Route Number, City or Town, State) 2800 DOCK Prospect St. 3 🗀 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 M Homicide determined Balto, Md street filled i To the Hospital within 24 hours e To the Funeral Completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

Pamela E. Southall, MM 32. Registrar's Signature 31. Date filed (Month, Day, Year)

JUL 1 9 2005

who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Panat Bouthalf NO

29c. License number OCME

111 Penn Street

29d. Date signed (Month, Day, Year)

July 15, 2005

Baltimore, Maryland 21201

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2000 KEBECCA ANN COLEMAN Jul /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore A Hopital N Sinan If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🗹 F Months Hours Min 052-14-4692 92 Yrs. Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 27 is marked other than "netural", or Items 23e or 28e-f show traumatic evant, the Medical Examinar must be notified at 1 Yes 2 No Director NA BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 1015 N. AUGUSTA AVENUL USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ BLACK 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "n any injury or other traumatic evant, the Medionce. Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS HAGGAR MANUFACTURING 10-TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ALICE COOPER WILLIAM CHAMBERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON) 1015 N. AUGUSTA AVE., BALTO. MD 21229 LAWRENCE PEELS 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 07.23.05 NEW CATHEDRAL BALTO. MD * 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licensee 5151 BALTO. NATU PIKE, BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final andwarescula dine ae Atemoselundic Physician upor? disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical anding phys IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 nonths?
1 □ Yes 2 □ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nnknown Completed 24a. Was an autopsy performed.
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2\(\sum \) No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 No 2 ER/Outpatient 1 Inpatient 2 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pendina 1 Tes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

ARIB 31. Date filed (Month, Day, Year)

Mulan

JUL 1 9 2005

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Sinai

32. Raistrar's Signature

DOOd1736

29d. Date signed (Month, Day, Year)

2005

		Unpend item#23a,27,28a- 1- State Registrer	Department of Health and M Certificate of Death	ental Hygiene	3477
Physici /Medic		1. Decedent's Name (First, Middle, Last) Eugene William Cost		Month Day Year	Time of Death
Examin	er	4a. Facility Name (If not institution, give street and number) Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last	4b. City, Town, or Location of Death Baltimore birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	4c. County of Death N/A	(State or Foreig
Director		213-54-4337		Dec. 17,1948 Mary	land Inside City Limits
the Mary 28a-f sh	Director	Maryland N/A 10e. Street and Number	Baltimore 101. Zip Code	10g. Citizen of What Country?	Yes 2□No
eath with	Funeral D	4630 Pimlico Road 11. Marital Status 12. Was Decedent Ever in U.S.	21215	USA	ndian
2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland is marked other than "neture!, or items 23a or 28a-f show aumatic event, the Maxical Exaction must be notified at	þ	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes 3 No	Was Decedent of Hispanic Origin? (Spetif Yes, specify Cuban, Mexican, Puerto Particular of the Specify: □ Yes 2 No Specify:	Black, White, etc. Specify: Black	
be filed within 72 h. Ital Hygiene. Id other then "netu event, the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)		
Permit. Pages 1 and 2 should be filed within 72 hours att operation and Mantal Hygiens and manderal Hygiens of manorient: if item 27 is marked other than "netural; or my injury or other traumatic event, Ita Maulcal Examinate.	Be	9th Grade 17. Father's Name (First, Middle, Last) Tony Swinson		Janitorial S (First, Middle, Maiden Sumame) Edward Cost	Servic
ages 1 and 2 should but of Health and Ment: if item 27 is marked or other traumatice	To	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rural 4630 Pimlico Road I	Route Number, City or Town, State, Zip Coo	
Pages 1 arment of Hea ent: if item:		20a. Method of Disposition 15-Burial 2 Cremation 3 Removal from State 20b. Place ceme	e of Disposition (Name of Distery, crematory or other place)	20c. Location - City or Town, 19/05 Woodlawn, Ma	State
permit. Page Department importent: it eny injury o		21. Signature of Funeral Service Licensee Levery Courts 23a. Part1. Enter the disease, or complications that caused the death. Description of the court of the	5240 Reisterstown	atman-Harris Fune: n Road Baltimore,	
The law requires that the death certificate be executed with the death certificate be executed with the has been signed by the ettending physicien and be detached for use as the burial-transit	edical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that nitiated events resulting in death) Last Due to (or as a consequence of the co	ce of):	On	arval Between set and Death
nat the death certific d by the ettending p felached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 9 ☐ Unknown	ath 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day	Year
for Attending Physicien: The law requires that after death. Director: After this certificate has been signed to in by the funeral director, page 2 should be det	by	Part II. Other significant conditions contributing to death but not resultin	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the ca	
	Completed			24a. Was an autopsy prior to comple death? 1 Yes 2 No 1 Yes 2 No	tion of cause of
Physicien: this certific al director,	To Be	A		(Check only one) ne 5 ☐ Residence 6 ☐ Other (Specify)	
Attending For death. ector: After by the funera	Certification:	1 □Natural 5 □ Pending (Month, Day Year)	nk Work? 1 Yes 2 XN ur , farm, street, factory, office	nk 281. Describe how injury occurred 281. Location (Street and Number or Rural Ro City or Town, State) 530 Pimlico Rd. Balti	
Hospitel or 24 hours afte Funerei Dir stely filled in	Medical	29a. Certifier (Check only) 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place, a	and due to the cause(s) and manner as stated	1.
To the within 2 To the comple	Me	29b. Signature and little of certifier	29c. License number OCME	29d. Date signed (Month, Day, July 10, 200	
	ite	30. Name and address of person who completed cause of death (Item 23 The state of the state of	111 Penn Street	Baltimore, Maryland	21201

JUL 1 9 2005 Been & Joseph ORIGINAL

		•	For State Registrar	State of Marylar		artment of H			iene 9. NA N	n 5	231.78
Р	hysici	an	1. Decedent's Name (First, Middle, Last) JAMES E.	CLA	DV			2. Date of Death Month 7	Day	Year 005	3. Time of Death 12:50 A м
	/Medic		JAMES E. 4a. Facility Name (If not institution, give s		IKK	4b. City, Town, or	Location of Death			ty of Death	
	. Admini		1612 Chestnut La	ane		Sever	'n		Anne	Arun	ide1
	ineral rector		5. Social Security Number 6. Sex 220–20–6145	7. Age (In yrs. 7		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 14,		9. Birth Cou M	place (State or Foreign intry) D
Pu	>		Usual Residence of Decedent 10a, State 10b, County	100 C	ity, Town or Lo	ecation					10d. Inside City Limits
laryla	show	5				Cation					1 ☐ Yes 2 ☐ No
the M	28a-1	Director	MD Anne Ar	rundel 5	evern	10f. Zip Code		11	0g. Citizen o	f What Cou	
death with the Maryland	Sa or		1612 Chestnut La	ine		1	21144			.S.A.	,,,,,
death	ms 2	Funeral	11. Marital Status	2. Was Decedent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-			ican Indian,
d Z I Z I 3-0030 filed within 72 hours after Hygiene.	"natural", or itams 23a or 28a-f shov officel Exercited must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:		1 ⊡ Yes 2 X No	Specify:	o Rican, etc.)	Spec	lack, White :ify: W	hite
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اة . الأ		Completed	(Specify only highest grade	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wor d)	king			
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Ta Se I	d other than "natu event, II.e Medical	Be (17. Father's Name (First, Middle, Last)					ne (First, Middle, M		ame)	
should men		2	Daniel C. Clark,		401 10 11			elen Yure		- Ct-1- 7	"- O- d-)
Vial 12 sh h and	7 Is marke traumatic		19a. Informant's Name/Relationship (Ty) Mrs. Debbie Rainie		1	ng Address <i>(Street</i> Chestnut					ip Code)
	item 27 I r othar tra		20a. Method of Disposition		Place of Dispo	osition (Name of			20c. Locatio		Town, State
Pages Pent of	t: If it y or o		1	emoval from State	cemetery, cre	matory or other plac	1			,	
Dallinore, permit. Pages 1 ar Department of Hea	Important: If i any Injury or once.		21. Signature of Juneral Service License			en Mem. P 2. Name and Addre					
permit. Departr	any one		Nustive Co.	Mis mol		l Second					
/Me Exa	physician and street a	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	Hens	y, such as cardiac	сог гозрпасогу апте	331 ,		Approximate Interval Between Onset and Death M & T S
the death certif	ed by the attending physici detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	f. 3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnanc	y			Date of deli Month	very Day Year
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	cate has been s page 2 should	Completed						24a. Was a autops perform	sy .	prior to death?	topsy findings available completion of cause of 2 \(\text{No} \)
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Division of To the Hospital or Attending Physe within 24 hours after death.	Director: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, s		Yes 2 □ No	28f. Location (Si City or Town		mber or Ru	ıral Route Number,
a Hospit	To the Funeral I completely filled	edicai (sician: To the best of my ki ner: On the basis of examination and manner stated.							
To the	To the	Me	29b. Signature and title of certifier	Doctor	^	29c. Licens	se number	2	29d. Date sig	ned (Monti	h, Day, Year)
•	10)	30. Name and address of person who co	ompleted cause of death (It	em 23a) (Type	, Print)	1, 00	1:1	A	1 1 >	DALLE MAL
	St	ate	31. Date filed (Month, Day, Year)	32. Revistrar's Sig	nature L	41 12	Jense	HIGHW	My 1	1000 L	rous / vin
- 5	Regist		JUL 19	LUUD Messue	A.	Carried Street					

			For Stata	State of M	Maryland				nd Mental Hy	_	00-	• 6.4
			Registrar 1. Decedent's Name (First, Middle, L.	acti		Cer	tificate of L	Jeath	2. Date of D	Reg. No.	005	23479
	Physicia /Medic		Lillian		ark				July	Day 18	2005	5:46a м
	Examin	24	4a. Facility Name (If not institution, gi	ve street and numbe	r)		4b. City, Town, or	Location of [County of Dea	ath
			Riverview Nur				Essex			Ba	ltimo	re
	Funeral Director		5. Social Security Number 107 16 5281	Sex 7. A 1 □ M 2 🖫 F	Age (In yrs. Ia 8	8 Yrs.	Months Days	If Under 24 Hours	Min. 8. Date of Bi (Month, D	rth ay, Ye <i>ar)</i> 7 . 19	9. Bir	rthplace (State or Foreign ountry) Oregon
	pug &		Usuaf Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	antion					
	Maryla f sho	tor	MD Baltime	ore		'owsor						10d. Inside City Limits 1 ☐ Yes 2 ☐ ※ O
	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What C	ountry?
	23a c	ai D	6451 North Ch	arles St	reet		2121	2		US	A	
' 0	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic avant. The Medical Example of thinst be collined at injury 8.	Funeral Director	11. Maritaf Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces	s?	3. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin n, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	0- 1-	4. Race - Ame Black, Whi	
21215-0036	ural', o	by	3√ Widowed 4 Divorced	1 ☐ Yes 2€ If Yes, Give Year or Dates	5: 		Yes 2 XNo	Specity:			Specify: W	nite
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	and 2 sl salth an n 27 Is r		Faye Simmons		er		-		or Rural Route Numl Baltimo:			Zip Code)
ore,	of Hea		20a. Method of Disposition 1 Surial 2 Cremation 3		20b. Pla		sition (Name of natory or other place		Date		ation - City or	Town, State
Baltimore,	permit. Pages Department of h Important: If ite any injury or of	1	*4 ☐Donation 5 ☐ Other (Spec	ify)		dowri	.dgeCeme	tery	7/21/0	Ba	Ltimo	re MD
Bal	permit. Page Department Important: If any injury or		21. Signature of Funeral Service Lice	1 On	well.	1 22	Name and Addres		Connelly Bal			omeofEssex
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	ofications that caus one cause on each	ed the death	not ente	er the mode of dying	g, such as ca	rdiac or respiratory	rrest,	, e mb	Approximate Interval Between
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	/Medical Examiner		1	Due to (or a	as a conseque	ence of):						
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Litter orderiving	b. Due to (or a	as a conseque	ence of):						
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or :	as a conseque	ence of):						
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Вох	death certifi e attending p id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	ne of pregnan 2 Fetal o		Ectopic pregnancy			23	3d. Date of de	
0.	0 0	Physician/Me	1 Yes 2 No	4□Pregnant 9□ Unknown		ath 5□	Other (specify)				Month	Day Year
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3ec	e law r has be je 2 sh	Completed	bledup,	Me		HTM	, CT	70	24a. Was	psy	24b. Were a	utopsy findings available completion of cause of
lal		e Co	25. Was case referred to medical						1 ☐ Yes	ormed? 2 DNo	death?	s 2 11 No
Š	Physician: this certific ral director.	0 B	examiner?	Hospital:	itient 2□E	R/Outpatien	t 3□ DOA Othe		f Death Check onling Home 5 Res		Other (Sn	acińi)
n of	ding Phy h. After thi funeral o	J: L	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of fr (Month, L	njury 2	28b. Time of fnjury	28c. Injury Work	at	28d. Describe			sciiy)
Siol	tandir Jeath. tor: Al the fu	ertification;	2 Accident investigations in Suicide 6 Could not	on he			M 1 🗆 1	res 2□No				
Division of Vital Records,	al or At after of Direct of in by	ertifi	4 Homicide determined	d 28e. Place of I	Infury - At hon etc. (Specify)	ne, farm, stre	eet, factory, office			(Street and wn, State)	Number or R	ural Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	edical C	29a. Certifier (Check only one)	Physician: To the bearing aminer: On the basis and manner:	of examination	vledge, death on and/or inv	occurred at the time	e, date and p inion, death	place, and due to the occurred at the time	cause(s) a date and p	and manner as place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		-,4500		29c. License					th, Day, Year)
	4		► /V/p	M.D			D-	387	54	07	-18-	2005
1	2		30. Name and address of person who	o completed cause of	f death (Item :	23a) (Type,	Print) BAS	TBR	IN BL	VD.	- M	0-21221
	Sta Registr		31. Date filed (Month, Day, Year)	dia .	strar's Signatu	ure 40	while					

			1 - For State Registrar	State of Ma	aryland	-	artment of hartificate of		d Mer	, ,	ene g. No. 2 N	0 =	221.00
	Physicial		Decedent's Name (First, Middle, Last	st)						Date of Death Month		UJ	3. Time of Death
6.	Physici /Medio		Matthew Mord						J	ULY		O5	1712 PM
	Examin	er	4a. Facility Name (If not institution, give 712 COUNTRY VILLA		APT	3D	BEL AIR	or Location of De	ath		4c. County		
	Funeral Director		5. Social Security Number 6. Social Security Number 1	ex 7. Aga ZYM 2□F		ast birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 H	in.	Date of Birth (Month, Day, Ly 2,	Year) 1949	9. Birthp Coun	lace (State or Foreign try) ifornia
	m w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						Od. Inside City Limits
	Maryli -1 sho	tor	Maryland Harford			l Air							1X Yes 2 No
	or 28s	lrec	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	Vhat Coun	itry?
	s 23a	rai	712 Country Vil				2101				USA	_	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28a-1 ehow other traumatic event, the Medical Exemple must be notified at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2021 If Yes, Give Year or Dates:			Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2☑ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify erto Rica	Yes or No- an, etc.)		e - Americ k, White,	
21215-0036	72 hou nature	eted	15. Decedent's Ed (Specify only highest gra	lucation		16a. Deced	dent's Usual Occup	pation	working	1	6b. Kind of Bu		
121	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	kind of work done DO NOT use retire	d)			- 171		
	filed v Hygie other t		17. Father's Name (First, Middle, Last)	<u>Z</u>		Opera	ations Su				Public Naiden Sumam		S
Maryland	should be nd Mental marked o	To Be	Matthew Mordic	a Cox, Si	c.						Medin		
Man	2 sho and h	i I	19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailir	ng Address (Street	and Number or	Rural Ro	oute Number,	City or Town,	State, Zip	Code)
	1 and 2 Heelth tem 27	1	G. Ann Northwood 20a. Method of Disposition	/ Sister	20b. Pl	402	Daniel C	ourt, B	el A		21014 Oc. Location -	City or To	State
OLL	Pages ent of nt: If It		1 ☐ Gurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1		natory or other pla femorial				el Air	45,870	
Baltimore,	permit. Pages 1 an Department of Heel Important: If Item 2 ony Injury or other ance.		21. Signature of Funeral Service Licen		DCI		Name and Addre				er Air,	PELL	yranu
0	20E 20) May T.	3		5	0 W. Bro	adway S	t.,	Bel Ai	r, MD 2	21014	
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each ling	the death ne.	. Do not ent	er the mode of dyl	HEMO	liac or re	spiratory arre	st,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ence of):							
W	acuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
09289	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequ	ence of):							
		edical	`	d									
P.O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending p rai director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у			23d. Dat Moi	e of delive	ny Day Year
	s that t ned by	by Ph	Part II. Other significant conditions of	ontributing to death b	ut not resu	Iting in the u	nderlying cause gr	ven in Part I.		23e. Did toba	acco use conti	ribute to th	e cause of death?
ords	* require: been sig should bi	led b	Chronic A	tcohole	SN				_	1 🗌 Yes	s 2□No	3 🗌 Prob	ably 4 Unknown
Division of Vital Records,	The law rate has be page 2 sh	Completed							-	24a. Was an autopsy perform 12 Yes 2	ed?	rior to cor leath?	psy findings available inpletion of cause of
Vita	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			0#	26. Place of D				1	COLLEGE
on of	iding Physin. In: After this funeral di	tlon: To	152 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry.	28b. Time of Injury	28c. Inju	ry at			nce 6XOthe		SCENE
Divisi	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined		ury - At ho	me, farm, str	eet, factory, office		28f.	Location (Stre City or Town,		er or Rura	I Route Number.
	To the Hospital within 24 hours e To the Funeral completely filled	edical	29a. Certifier (Check only one) 1 ☐ Certifying Ph 2√2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	examinat	vledge, death ion and/or in	n occurred at the ti vestigation, in my o	me, date and pla opinion, death or	ace, and ccurred a	due to the car t the time, da	use(s) and ma te and place, a	nner as st and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1000		Λ	29c. Licens				d. Date signed		
,	.0.		20 Name and address of across	Halla	WV	ud	D-i-n)					4, 20	
	14		30. Name and address of person who dead the control of the control) //V	21		nn Stree	et]	Baltimo	ore, Ma	rylar	nd 21201
	Sta Registr		31. Date filed (Month, Day, Year)	9 2005 Reg	ars Signat	ure J.	Gara						

	P [°] nysici	an	1 - State AMEND ITEM #5 PER G846 8/04/05 J n. Decedent's Name (First, Middle, Last)	Month Day Year	_
	/Medic		Mary Allen Carroll	July 14 2005 10:30 a M	
	Examin	er	4a. Facility Name (If not institution, give street and number) 469 Commerce Street	4b. City, Town, or Location of Death Havre de Grace 4c. County of Death Harford	
	Funeval		5. Social Security Number Un ¥ 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State of Faccion	_
L	Funeral Director		220-32-3172	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 20, 1908 9. Birthplace (State or Foreign Country) MID	
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation 10d. Inside City Limits	
	a-1st	ctor	MD Harford Havre of	le Grace 1□Yes 2귳No	
	or 28	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	
	s 23a	ral	469 Commerce Street	21078 USA	
936	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural, or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 Tyes 21√2 No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☎ No Specify: 14. Race - American Indian, Black, White, etc. Specify: white	
200	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	_
2	ithin ne.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
2	filed w Hygier Sther ti		17. Father's Name (First, Middle, Last)	11 Worker Healthcare 18. Mother's Name (First, Middle, Maiden Surmame)	_
Maryland 21215-0036	2 should be f and Mental H is marked of aumatic eval	To Be	Thomas Milton Carroll	Christine Lay	
	and 2 sho fealth and m 27 is m har traum	1	The priew	ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Straberry Lane, Havre de Grace, MD 21078	
altimore,	permit. Pages 1 a Department of Hea Important: if item any injury or otha once.			osition (Name of Date 20c. Location - City or Town, State	
Ě	permit. Pages Department of Important: If it any injury or o once.		`4 □Donation 5 □ Other (Specify) Chesapeake	Grematory Inc. 7/16/2005 Beltsville, MD	
Ba	permit. Departr Importa any inje		21. Signature of Funeral Service Licensee	AFA, Stephen D. Lohrmann, PA 717 Green Pastures Drive, Towson, MD 21286	
	Priysician		Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Cardio Adular dusers.	
	/Medical Examiner		resulting in death) a. Use to (or as a consequence of): Sequentially list conditions.	miles	
	ecuted and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nentra	
	icate be executed physician and s the burial-transit	dical E	Due to (or as a consequence of): d		
.O. Box 6	death certif e attending d for use a	Physician/Me		□Ectopic pregnancy 23d. Date of delivery Month Day Year	
rds, P.	The law requires that the de ite has been signed by the a rage 2 should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the u	ndertying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
		Completed		24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
/ita	clan: ertific sctor,	Be (25. Was case referred to medical examiner?	26. Place of Death Check on one	
5	Phyais this or	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier		
טחכ	ding P. h. After funera	lon:	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	
Division of	Hospital or Attending Phyaiclan: 44 hours alter death. Funaral Director: After this certificately filled in by the funeral director,	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, streaming building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	e Hospital of 24 hours at a Funaral Dietely filled i		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only 2 Madical Examinar: On the basis of examination and/or in	n occurred at the time, date and place, and due to the cause(s) and manner as stated.	-
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	one) and manner stated. 29b. Signature and title of certifier	vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date_signer/(Month, Pay, Year)	-
1	1		* FLEM.D	Do 66 / 1/5/6t	
9			30. Name and address of person who completed cause of death (Item 23a) (Type,	ust Haurede GEACE, 4D 21078	
•	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	parke	

			1 ← State	State of Ma	aryland.	•	rtment of l				- 20100
		-	Registrar 1. Decedent's Name (First, Middle, Last	1)		Cen	ilicate of	Dealli	2. Date of Dea	Reg. No 200	3. Time of Death
	Physici /Medic			utter					July	16, 200	ar
	Examin	er	4a. Facility Name (If not institution, give					or Location of Deat	h	4c. County of D	
	Format		2211 W. Roger: 5. Social Security Number 6. Se		e (In yrs. last	t hirthday)	Ball If Under 1 Year	imore	8. Date of Birtl	N/	
	Funeral Director			_M 200 F	94	Yrs.	Months Days	Hours Min.	Sept. 1	3, 1910	Birthplace (State or Foreign Country) Maryland
\$	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Loca	ation				10d. Inside City Limits
Q6:15AM	n the Marylar r 28a-f show	tor	Maryland N/A		E	Baltim	ore				1X□Yes 2□No
9	th the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	t Country?
	ath wi	rai	2211 W. Rogers				212			United	States
Her 2005 36	ltams	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?		13. W	as Decedent of h Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
14 H 6-26	filed within 72 hours after death with the Maryland Hygiene. Ahar then "natural", or Itams 23a or 28a-f show int, I've Medical Examination of the notilised at	To Be Completed by Funeral	3 X Widowed 4 □ Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	10	10	☐Yes 21X No	Specify:		Specify: W	hite
545	72 ho 'natur	eted	15. Decedent's Edu (Specify only highest grad	ucation le completed)	1	16a. Decede (Give ki	nt's Usual Occup ind of work done	oation during most of wo d)	rking	16b. Kind of Busine	
121	within ene. then '	mp	Elementary/Secondary (0-12)	College (1-4or 5				a) Cion Guida			timore City chools
EXP.	il Hygi other	e C	17. Father's Name (First, Middle, Last)			pecia	Lauca			Maiden Sumame)	0110013
Ja ra	2 should be and Mental is marked of sumetic eve	To B	Edward J.	Roberts				Flo	rence	Harker	
Gr Ex Maryland	01 00 00 00		19a. Informant's Name/Relationship (T)							r, City or Town, Stat	
	lan Heal In 2		Mr. N. Craig Cutte	r / Son			tion (Name of atory or other pla		e TOWSO	n, Maryla 20c. Location - City	
Baltimore,	permit. Pages: Department of H Importent: If ite eny injury or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		i i		etory or other pla Park Cei	ı	, 19 2005		wn, Maryland
atti	permit. Departm Importer eny inju		21. Signature of Funeral Service Licens		. Canap	p 22.	Name and Addre			305 Harfo	
_	89558		Missing,	<i>.</i>						altimore,	MD 21214
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused ne cause on each lin	the deeth. D	Do not enter	the mode of dyi	ng, such as cardia	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. END-S	TAGE	Co	NGEST1	VE CA	RDIOM)	OFATHY	/
	Examiner		Conversion to the same statement	CORDA	ARY	Al	ETLEY	DISEA	SE		
./	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequen	ice of):					
V	xecute and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequen	ice of):					
8760,	cate be executed ohysiclan and the burial-transit			d							
89	rtificat ng phy s as th	Medi	IF FEMALE:								
Box 68	Attending Physician: The law requires that the death certificate be executed in death. If death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetel dea	ath 3 □E	ctopic pregnanc	y		23d. Date of Month	delivery Day Year
P.O.	t the de by the	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death	n 5 🗆 (Other (specify) _				
ď.	es that Igned b	by PI	Part II. Other significent conditions co	ntributing to death bu	ıt not resultin	ng in the und	lerlying cause giv	ren in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
ord	aw requires is been sign 2 should be	Completed by	ANEMIA; CHR	onic Pla	NAL I	-AILU	RE		1 🗆 Y	8s 2□No 3□	Probably 4 Unknown
ec Sec	has b	mple							24a. Was a autops	sy prior	autopsy findings available to completion of cause of
E E	ilcian: Th certificate rector, pag	CO	25. Was case referred to medical							2 No 1 Y	/es 2□ No
₹	ysicla s cert	To Be	examiner?	-lospital: 1 ☐ Inpatier	nt 2□ER/	/Outpatient	3□ DOA Ott	1187	th <i>Check on</i> on	ence 6 □Other (S	Snacihi)
n 0	ding Phys J. After this funeral di		27. Manner of Death	28a. Date of Injur (Month, Day		b. Time of Injury	28c. Injur			ow injury occurred	розлуу
Sio	ttendii death. stor: A / the fu	catio	2 Accident investigation 3 Suicide 6 Could not be				M 1 🗆	Yes 2 □ No			
Division of Vital Records,	after of Direction by in by	Certification;	4 Homicide determined	28e. Place of Inju building, etc	iry - At home. :. (Specily)	, farm, stree	t, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely tilled in by the funeral director, page	edicai C	Check only 2 Medical Exami	sician: To the best of ner: On the basis of	examination	dge, death of	occurred at the tir stigation, in my o	me, date and place	, and due to the c rred at the time, d	ause(s) and manner ate and place, and o	as stated,
	o the ithin 2 o the omplet	Med	one) 29b. Signature and title of certifier	and manner sta	ted.		29c. Licens			9d. Date signed (Mo	
	6 4 € 4		PKoleSTE. (K	Elymas),		_	9425		07/16/2	
	•		30. Name and address of person who co	ompleted cause of de	eath (Item 23	Ba) (Type, Pr	rint)				- 10 40
-	10		ROBERT E. P.	BY M.D	-221	1 W.	ROGER	S AVE-	BATIM	ORE MI	2/209
	Sta Registr		31. Date filed (Month, Day, Year)		r's Signature	Low	E)			•	

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H			jiene	05	23483
· · · · · · · · · · · · · · · · · · ·	Physici /Medi		1. Decedent's Name (First, Middle, La Mark E. C	,	sky			2. Date of Dea Month July 16	Day	Year	3. Time of Death 9:45 P M
	Examir		4a. Facility Name (If not institution, giv 15709 Sycamore G			4b. City, Town, or Rocky		ath	4c. County	y of Death comery	7
	Funeral Director				(In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi				lace (State or Foreign
	the Maryland 28a-f show	ctor	Usual Residence of Decedent		10c. City, Town or Lo	ocation ville				11	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	Dire	10e. Street and Number 15709 Sycamore G	rove Court		10f. Zip Code	853	1	10g. Citizen of United		
5-0036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland to Health and Mental Hygiene. If Item 27 is merked other then "natural", or Items 23a or 28s-f show or other traumatic event, the Medical Examinar mast by morthled at	ed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1Yes 2XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No dent's Usual Occup	Specify:	(Specify Yes or No- erto Rican, etc.)	14. Ra	ce - Americ ck, White, o fy: wh	an Indian, etc. lite
21215	l within 72 liene. r than "na	Completed	(Specify only highest gra Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired repreneur	during most of w	rorking	Writin		lustry
Maryland 2	12 should be filed within " h and Mental Hygiene. 7 Is marked other than " traumatic event, the Med	To Be C	17. Father's Name (First, Middle, Last Milton Chorvin			-		ame (First, Middle, Shainberg	Maiden Sumai	ne)	
	1 and 2 sho Health and P em 27 Is me other traume		19a. Informant's Name/Relationship (Laurel Chiat, wi		1570	9 Sycamor		Rural Route Number Court, Re			· -
Baltimore,	permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 № Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Signature of Funekal Sarvice)	(y)	Judean Me	matory or other plac morial Ga	rdens	/18/05	20c. Location Olney, Home		wn, State
	Physician /Medical Examiner	I Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only timmediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c.	he death. Do not en	ter the mode of dyin	g, such as card		ngton, est.	DC 2	Approximate Interval Between Onset and Death
O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)				ate of delive	ry Day Year
rds, P	quires tha	by	Part tt. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to		tribute to th	e cause of death? ably 4 Unknown
al Records,	10	Completed							med?	prior to con death?	osy findings available inpletion of cause of
f Vital	Physicien: this certificantal director,	To Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital:	t 2 ER/Outpatie	nt 3 DOA Oth		Home 5 Reside	ne) ence 6 □Ott	ner (Specify	1)
ion of	Attending Ph r death. sctor: After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Year) 28b. Time o	Wor	yat k? Yes 2 □ No	28d. Describe he			
Division	Dir	Certification:	3 Suicide 6 Could not be determined		y - At home, farm, st (Specify)	reet, factory, office		28f. Location (S. City or Town		ber or Rurai	Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best of miner: On the basis of e and manner state	examination and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the c curred at the time, d	ause(s) and m late and place,	anner as stand due to	ated. the cause(s)
	To the Ho within 24 I To the Fu completely	Ň	29b. Signature and hitle of certifor	DIRECT MEDICA	ORI	29c. Licens	- 41	0	July 1		
	10		30. Name and address of person who	completed cause of de-	ath (Item 23a) (Type,		thune	,MD 21	287		
**	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 9 2005	32. Registrar		% s					

68760,	
Box.	
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Vital	
of	
Division	

		1 - State Registrar						artment of tificate of				Reg. N	201	0.5	231.01
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anin	iei	Gilchrist	_		,			Towso		or Boati				timo	
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k	/Medic	al	cecella D	Unn			O': 7		July		, 2005	
	Examin	er	4a. Facility Name (If not institution, give s Johns Hopkins Ba		Jursir			r Location of Dea		40	. County of Dea	ith
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last	birthday) If I	Inder 1 Year		s. 8. Date of Bir	th V Year	9. Bir	rthplace (State or Foreign ountry)
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	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland refinent of Health and Mental Hygiene. ordant: If tem 27 is marked other than "natural; or tama 23a or 28a-f show injury or other traumatic event, the Maxical Examinat must be notified at any or other traumatic event, the Maxical Examinat must be notified at 9.	Dire	10e. Street and Number 5341 Wright Aver				of. Zip Code				tizen of What C	*
	Jeath Trust	eral		2. Was Decedent B	ver in U.S.		21205	lispanic Origin? (ted St	
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Division of	after deatl	Certification;	4 Homicide determined	28e. Place of Inju- building, etc.		farm, street, fa	ctory, office		28f. Location (S City or Tox	Street an vn, State	nd Number or Ru)	ural Route Number,
	To the Hospital or Attending Physician: white 24 hours after deals as a feet deals of the Funeral Director: After this certification to the funeral director.		29a. Certifier 1 Certifying Physi	cian: To the best o	my knowled	ge, death occu	rred at the tim	ne, date and plac	e, and due to the	cause(s)	and manner as	stated.
	o the Ho eithin 24 h o the Fu ompletely	edical	(Check only Medical Examina	er: On the basis of and manner stat	examination a	and/or investig	ation, in my op	pinion, death occ	urred at the time,	date and	place, and due	to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. 2.005 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Solomon Leroy Eaddy 4.70 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE GOOD SAMARITAN HUSATAL N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 14, 1931 Birthplace (State or Foreign Country) **Funeral** 250-36-2641 XXM 2□F Director 73 Yrs. S.Carolina Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "neturel", or Items 23e or 28a-f show treumatic event, the Modical Examinar mant be notified at Maryland Baltimore Cockeysville 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 264 Lord Byron Lane 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give 1 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steelworker Bethlehem Steel 8th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Eaddy Idell Barr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other tree once. Mary Eaddy/ Wife 264 Lord Byron Lane Cockeysville, MD 21030 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 7/1^{Date}/05 Maurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Rest Cemetery Towson, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd. Baltimore, MD21215 fo amo evoy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit certificate be executed DIABETES MELLITUS that initiated events resulting in death) Last Due to (or as a consequence of): SEVERE Physician/Medical MALNUTRITION 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by CONGESTIVE HEART FAILURE 3 Probably 4 Unknown CHRUNIC PANCREATITIS PEPTIC ULCER 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ate has page 2 s autopsy performed? DISEASE, ATRIAL PIBRILLA TION 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Certification: To Be 26. Place of Death Check onl one 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Many or of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation after death. 1 Yes 2 No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Director completely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) MD RES 000 30. Name and ado ess of pe son pleted cause of death (Item 23a) (Type, Print) JIMMY M HEWRY IMD LUCH RAVEN BLUD 5601 BALTIMORE MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

SOLOMON

EADDY

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death
			1. Decedent's Name (First Middle Last)
н	Physicia		ELEGNOR M. FORD July 15 2005 0924M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	LXuiiiii	Ŭ.	STELLA MARIS NURSING HOME TIMONIUM BALTIMORE
	Funeral		5 Social Security Number 6 Sex 7 And (In virs last highdrey) If Under 1 Year If Under 24 Hrs 9 Date of Right
	Director		212-09-0799 10 M 20 96 Yrs. Months Days Hours Min. Jan 18,1909 Country MD.
	pr ,		Usual Residence of Decedent
	aryta show	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	8a-f	cto	MD BALTIMORE TIMONIUM 10 Yes 20 No
	vith ti	Ö	10e. Street and Number 2300 Dulaney Valley RA 10f. Zip Code 10g. Citizen of What Country? 21093 U.S. A
	s 23s	Funeral Director	
	ter de	un.	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 2 Married 3 Married 4 Married 5
39	irs af	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Speci
21215-0036	72 hours after death with the Maryland natural', or Itams 23e or 28e-f show dical Exam in must be motified at		15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
215	hin 7 9. 8n "n Medi	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)
21	e filad within al Hygiene. I othar than " vant, I'le Mai	Completed	12th NA SEAMSTRESS TAILOR CORP.
nd	al Hy al Hy doth	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
yla	Ment Ment arka atic	To Be	JESSE HART ELLEN BROWN
Maryland	2 shd and Is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	nit. Pages 1 and 2 should be filad within 72 hours after death with the Marylan artment of Heatth and Mental Hygiene. ortant: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show injury or other traumatic avant, the Medical Exumination in infinite at a 18.		JAMES . H. FORD 912 BEAVER BANK CT, TOWSON MD. 2 286
lor	ges it of h		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
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Baltimore,	permil. Pages Department of Important: If i any injury or once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City o
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	Ph sician / /Medical		disease or condition resulting in death) a. Con estive Herry Francisco
	Examiner		Due to (or as a consequence of):
		ег	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):
	uted d ansit	Examine	Cause (Disease or Injury
ó	axec an an rial-tr	Еха	resulting in death) Last Due to (or as a consequence of):
8760,	tate be axecuted by sician and the burial-transit	Physician/Medical	d
9	ntifica ng ph	Med	IF FEMALE:
Вох	death certific e attending pl d for use as t	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
	0 0 0	sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Month Day Year
P.0	that the di ad by the detached	Phy	9 Unknown 9 Unknown
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ΖΞ	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No
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ā	in Dira	erti	4 Homicide building, etc. (Specify) City or Town, State)
	To tha Hospital or Attan within 24 hours after deat To tha Funaral Diractor: completely filled in by the	Saic	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	ha Ho in 24 ha Fu pletel	edicai	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
•	A		1/16/55 1/16/55
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
			2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Sta R egistr	te ar	31. Date lieu (Month, Day, 1921) 9 2005 32. Resistrar's Signature
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 0-30PM AVIS M. FAGAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA GENESIS BALTIMORE ELDER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1□M 2**M**F 219.12.7319 81 Director Yrs Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location rai', or items 23a or 28a-f show Examiner ount be notified at 1 MYes 2 □ No Director BALTIMORE MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code BRADDISH AVENIUE 2021 LISA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 PNo Specify: BLACK 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Flementary/Secondary (0-12) other than College (1-4or 5+) ADMINISTRATOR 12-TH GRADE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRED SMITH ELEANOR STATON ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2021 BRADDISH AVE . , B Health tem 27 i DORINE SMITH SISTER BALTO. MD 21216 item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⚠Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 07.22.05 ARBUNUS BALTO. MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee VAUGIIN C. GREENE FUNERAL SERVICE 5151 BALTO. NATI PIKE BALTO, MD 21229 ano 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 - Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Certification; To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 Yes 2 No 1 🗌 Yes 2/2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 420 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2**∀**No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide within 24 hours a To the Funeral [10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and tiffe of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 024 J4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Ce	ertificate of	Death		Reg. No 1	15 231.93
		Dhysisian	1. Decedent's Name (First, Middle, La	ast)				2. Date of Dea	ath Day	3. Time of Death
_ 4		Physician /Medical	Lillian A. Fito	:h				July	17 2	ODF 5:29 PH
3		Examiner	4a Facility Name (If not institution, gir				4b. City, Town, or Loc			
0			Cromwell Center	-Genesis Elde	rcare		Baltimore	2	Balt	
2		uneral irector	219-28-3817	Sex 7. Age (In yrs	: last birthday Yrs.	y) If Under 1 Yea Months Days	Hours Min.	8. Date of Birt (Month, Day March	h y, <i>Year)</i> 3, 1933	9. Birthplace (State or Foreign Country) Maryland
-}	pue	ž	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or I	Location				10d. Inside City Limits
1	e Meryl	or 28a-f sho be notified a Director	Md. Harfor			Bel Air	c			1⊠ Yes 2□ No
5	h with th	st be no at be no al Dire	10e. Street and Number 232 Crocker Dri	ive		10f. Zip Code 210	014		10g. Citizen of W	201100
+	deat	ner ner	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	J,S. 13		Hispanic Origin? (Spec ban, Mexican, Puerto F	cify Yes or No-	14. Race	- American Indian,
I	Maryland 21215-0020 d 2 should be filed within 72 hours efter	7 is marked other than "naturel", or items 23a or 28a-f show traumetic event, the Medical Examiner number notified at To Be Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 Yes 2 No		ucan, etc.)	Specify:	k, White, etc. white
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	121 militari	di di	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of working ed)			
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	anc lbe fi	B se)			18. Mother's Name			a)
	Ty bould	Tark To	Joseph Carey 19a. Informant's Name/Relationship	Total Brief	405 44-3		Lillian			O 710.44
	Ma	traur traur	Carroll Fitch/h			_	ot and Number or Rural Orive, Bel			
	region L	other	20a. Method of Disposition	20b.	Place of Disp	position (Name of		Date		City or Town, State
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	Bal Permi	any ir	21. Signature of Funeral Service Licer	s Rineker	. '		ess of Facility ek Funeral MacPhail Ro			
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		<u> </u>		Due to (or as a conse	equence of):				1
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	0.0	the el hed for	Part II. Other significant conditions of	ontributing to death but not res	sulting in the	underlying cause gi	iven in Part I.	23b. Did to	obacco use con	tribute to the cause of death?
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	<u>a</u>	ls certificate has director, page 2 To Be Comp						104	as 200 No	1 □ Yes 2Д No
	ita E :	certificate rector, peg	25. Was case referred to medical examiner?				26. Place of Death	Check only or		
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	0 E	the funerel cation:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time (of 28c. Inju Wo	ry at 28 ork?	d. Describe h	ow injury occurre	d
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	Division To the Hospital or Attendit within 24 hours effer deeth	To the Funeral Director: After it completely filled in by the funera Medical Certification:	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deal	th occurred at the ti	ime, date and place, an opinion, death occurred	d due to the c	ause(s) and mar late and place, a	ner as stated. nd due to the cause(s)
4	To the	To the comple	29b. Signature and title of certifier	Houding	Phy	29c. Licens	se nember	42	29d. Date signed	(Month, Day, Year)
		6	30. Name and address of person who	completed cause of death (Iter	n 23a) (Type	Print) Rave	n Blud	303	Balt.	mu 21239
		State Registrar	31. Date filed (Month, Day, Year)	32. Redistrar's Signa		•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** FISCHER 3:24 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** tXXM 2□F Director 76 214-22-7435 Nov. 5,1928 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland and chealth and Mantal Hyglene.
net: If Item 27 is marked other than "netural", or Items 23a or 28a-f show any or other training oven. It has Madical Examiner must be millihed at yor other training oven. It has Madical Examiner must be millihed at 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland Dundalk 1 ☐ Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 6733 Roberts Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2½ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Heavy Equipment 10 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Jahnke 2 Herman Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6733 Roberts Avenue Dundalk, Maryland 21222 Dorothy Fischer Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State parmit. Paga Dapartmant o Important: If any injury or once. 4 Donation MOther (Specify) Entombment Oak Lawn Cemetery 7/18/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final Physician DAYS disease or condition resulting in death) UREMIA /Medical Due to (or as a consequence of): Examiner MONTHS CANCER DISSEMINATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and I-transit The law raquiras that the death certificate be executed Due to (or as a consequence of): attanding physician a for usa as tha burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 1 No 24a. Was an autopsy performe 2 No 1□ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funaral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Aftar Certification: 1 Natural 5 Pending investigation after daath. I Diractor: Aff d in by tha fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD, PhiD 3334 RES-000 JULY 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBNISHISH BOSE, JOHNS HOPKIN'S BROVIEW MEDICAL CENTER; 4940 EASTERN MENUE, BALTIMORE, MD 21224 31. Date filed (Month, Day, Year) State Registrar JUI 1 9 2005

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	tems tems	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Decedent of H	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		American Indian, Vhite, etc.
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Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licen	LINES TO SERVICE TO	Cain	22. Name and Addre 5305 Harf	ss of Facility L	eonard J. Baltimor	. Ruck,In re, Maryl	c. and 21214
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	To the Hospital c within 24 hours at To the Funaral D completely filled in	Medical	(Check only 2 Medical Examone)	iner: On the basis of examiner stated.	mination and/or i	nvestigation, in my o	pinion, death occu	irred at the time, da	ite and place, and	due to the cause(s)
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	SH		30. Name and address of person who of	completed cause of death	(Item 23a) (Type	Print)	N. C-10-	ene Str	reet Bi	105 altimore, MJ 21201
	Sta	ite	31. Date filed (Month, Day, Year)	82. Registrar's S	Signature	, , ,	, 0, 0	-/10 - 11		1/19
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			Please 1 - State Registrar	State of Ma	ryland / Dep		Health and M	ental Hy		gible. 05 23496	
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Maryl	Ith and Me 27 is mark r traumetia	To	19a. Informant's Name/Relationship (Benjamin Minah	Type, Print) Husband	19b. Maili 2 1 2 0	ing Address <i>(Street</i> Randolp	t and Number or Rura	l Route Numbe	er. City or Tow	m, State, Zip Code) Spring, MD	
P	gned by the attending physical be detached for use as the	ompleted by Physiclan/Medical Examiner	20a. Method of Disposition 1	plications that caused it one cluse in each line a. Respira Due to (or as a b. Metasta Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Gate Of 2 17 he death. Do not en. tory Arr consequence of): tic Breaconsequence of): consequence of): f pregnancy Fetal death me of death 5	Heaven 2. Name and Addre 7 2 2 Nort ter the mode of dyi Cest Let Canc Cher (specify)	ice) 7-23- ass of Facility Tay Tay	23e. Did to	Silve Fune NW W: rest, 23d. E	Approximate Interval Between Onset and Death Date of delivery Month Day Year ontribute to the cause of death? 3 Probably 4 Unknown	1
al Re	icate has	O						autop perfor 1 Tes	rmed?	prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \)	
of Vital	this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes ♣ No	Hospital: 1 🔀 Inpatient	2000	Ott	26. Place of Death				
ן ס ר אין מיני	ter this	-	27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Time o	nt 3 DOA 28c. Inju	ner: 4 ☐ Nursing Hon ry at 2	ne 5 ∐ Resid 8d. Describe h			-
ivision	ter death. irector: Af by the fu	Certification:	1XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	1	y - At home, farm, st	M 1]Yes 2□No	8f. Location (S City or Tow	Street and Num m. State)	mber or Rural Route Number,	
Division Division	within 24 hours after death. To the Funeral Director: After this certificate has been s' completely filled in by the funeral director, page 2 should	edical Cer	Check only 2 Medical Exan	ysician: To the best of niner: On the basis of e	xamination and/or in	h occurred at the ti	me, date and place, a	nd due to the o	cause(s) and r	manner as stated. e, and due to the cause(s)	
	within 2 To the complei	Med	29b. Signature and title of certifier	2 MD	90.	29c. Licens D 0 0			29d. Date sign	ned (Month, Day, Year)	
	5		30. Name and address of person who Lana Bur	completed cause of dea 160(ath (Item 23a) (Type,) Forest	Glen R	d., Silv	er Spr	ing,	MD 20910	
	. Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	All a					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. 2.00 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:05 AM ARQ mm 7001 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death RAVEN (TENNESIS RAVEN BALTIMORE Loch Loch If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country)
 A Funeral 1 M 2 F Months 217-20-6064 9 Davs Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location or 28a-f show 10d. Inside City Limits treumatic event, the Madical Examinar must be notified at MD BALTIMORE PARKUILLE Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Kose U.S.A PetAL 2123 Itams 23a Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "netural", or Ital 1 Yes 2 No If Yes, Gwe Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 □ Divorced Specify: WhiTe Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12+6 CLERK Loumans STOKE MIN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RoberT LYNCH ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 DarLene Rose RETAL MOORE Balto.Mo CT. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State Department of Interportant: If ite 1-Burial 2 □ Cremation 3 □ Removal from State 7/20/05 4 Donation 5 Other (Specify) PARKWOOD cem. 21. Schature of Funeral Service Licensee 22. Name and Address of Facility STELLA FUNCIAL HORE HARTLEY MILLOR RO. Bath. MO 21274 CHTO. eny ir tella Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executad attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s baen signad by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 XUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate 1 Yes 1 Yes 2 ☑ No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DQA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident aspital c.
4 hours after dea.
- real Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier

State Registrar

60

32. Reastrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) JU LV **Physician** MITSUE GWYNN 2005 /Medical 4b. City, Town, or Location of Deetly 4a Fecility Name (If not institution, give street end number) Examiner UPPER CHESAPEAKE MEDICAL CENTER 8. Date of Birth (Month, Day, Year) HARFORD Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1□M 2**Ø**F Days Months Hours 212 42 1959 JÁPAN Director Usuel Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director MD. HARFORD ABDINGON 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3034 CLARKSON DRIVE 21009 U.S. OF A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: JAPANESE ģ 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 YEARS 12TH CLERK MARKETING and Mentel Hygie marked other t 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SHONOSUKE AOYAMA MASUNO TSUKIMURN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21009 19a. informent's Name/Relationship (Type, Print) 60 Department of Health e Important: if item 27 is any injury or other tra once. PATRICIA M. GWYNN (DAUGHTER) 30 34 CLA a. Method of Disposition 1 Paging 2 Community 3 Removal from State 1 Paging 2 Community 3 Removal from State 1 Paging 2 Community 3 Removal from State 1 Paging 2 Community 3 Removal from State 1 Paging 2 Community 3 Removal from State 1 Paging 2 Community 3 Removal from State 1 Paging 3 Removal 3034 CLARKSON DRIVE ADPINGDON, MD. sition (Name of Date 20c. Location - City or fown, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/07/2005 BALTO, MD 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK 21. Signature of Funeral Service License WIS T. 22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 GWYNN 4517 PARK HEIGHTS AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** JEP-515 Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of): SMALL CELL LUNG CANCER Due to (or as a consequence of). Due to (or as a consequence of). PAREMONIA /Medical Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown FRY DISEASE þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 TYUS 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ this filled in by the funeral 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Naturel 2 Accident 5 Pending investigation 1 Yes 2 No death. Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 To the Hospital o within 24 hours eff To the Funeral Di completely filled in edicai (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7/2/2005

Registrar DHMH 16 Rev 6/95

State

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Serve H. Specker

ANWSHA SIRITHARA, 21/2 BEIGIR HOAD SUITE 10, FALLSTON, MD 2/047

Physici	an	State Registrar Decedent's Name (First, Middle,	Last)	C	ertificate	of Death	2. Date of Dea Month		5 2349 3. Time of Deat	
/Medic	al		Clinton	Gott	1 21 -	· · · · · · · · · · · · · · · · · · ·	JUL	Y 16, E	'ear 2005 9:00P	
Examin	ier	4a. Facility Name (If not institution,		Center			owson		Death Baltimore	
Funeral Director		5. Social Security Number 216-09-0296 Usual Residence of Decedent	6. Sex 7. Age 1 X M 2 ☐ F	91 Yrs	Months	Year If Under Days Hours	8. Date of Birth (Month, Day) Oct 27		Birthplace (State or For Country) Maryland	
28e-f show offified at	Director	10a. State 10b. County Maryland Balti 10e. Street and Number	more	10c. City, Town or	keysvi1				10d. Inside City Lim 1 ☐ Yes 2 📉	
3a or	ai Dir	10320 Malcolm (direle, ant.	D	10f. Zip C		1	Og. Citizen of Wh.		
"naturel", or items 23a or 28e-f show idical Examiner must be notified at	d by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?	ver in U.S. 1		nt of Hispanic Orig Cuban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)		American Indian, White, etc.	
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~ = =		1 ☐ Burial 2 X Cremation 3 1 ☐ Donation 5 ☐ Other (Spe			rematory or other	1.7	/21/05 rematory		Mary1and	
Department Important: any injury conce.		21. Signature of Fune Learn of Michael J. F	lagle		22. Name and	Address of Facility				
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el Directo ed in by th	Certification:	3 Suicide 6 Could not determine		y - At home, farm, s (Specify)	street, factory, of	fice	28f. Location (Str City or Town	eet and Number o , State)	r Rural Route Number,	
ne Funer	edicai	29a. Certifier (Check only one) 1 Certifying 2 Medicel Ex	Physicien: To the best of eminer: On the basis of e and manner state	examination and/or	ath occurred at the investigation, in	he time, date and my opinion, death	place, and due to the ca occurred at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)	
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0,	-	30. Name and address of person wh	no completed agree of de-	ath (Itam 02c) CT		416			2003	

			For State Registrer	State of M	aryland		artment of tificate o		and Mental H		2005	23500
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	/Medic	cal	Paul Fran						July	15, 2	005	10:45 PM
	Examin	er	4a. Facility Name (If not institution 3102 J Cardina		r)			, or Location o	f Death	4c.	County of Deat	
	Funeral		5. Social Security Number	6. Sex 7. A	ige (In yrs. las	st birthday)	Abingdo	ar If Under		Birth	Harfor	Q hplace (State or Foreign untry)
þ.	Director		265-29-1120 Usual Residence of Decedent	1 X M 2□F	50	Yrs.	Months Day	rs Hours				rmuda
	nylanc show	_	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
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Baltimore,	m O		20a. Method of Disposition 1 Burial 2X Cremation		e cen	netery, cren	sition (Name of natory or other p	' 1	Date	20c. Lo	cation - City or 1	Fown, State
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			23a. Part . Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. line.	Do not ente	er the mode of d	ying, such as	cardiac or respiratory	arrest,		Approximate Interval Between
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Вох	death certif e attending ad for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal d	eath 3	Ectopic pregnar	псу		2	23d. Date of deliving	very Day Year
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	ro the vithin 3	Med	29b. Signature and title of certifier	and manner s	^			nse number			e signed (Month	
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	10		30. Name and address of person of Name and address of person of Name and Address of Person of Name and Na	0. 1602	death (Item 2	(3a) (Type, 1 A	Print) Wood	Road	7 200,	Bel	Air, M	2005 D21014
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